REDDING ALLERGY & ASTHMA SPECIALISTS

**Patient Name: _____ Birthdate: _____**

**FINANCIAL AGREEMENT**

**Please read the following Financial Policy and sign below:**

At Redding Allergy and Asthma Specialists, we require patients to arrange for payment for all billed services at the time of service. This helps us reduce our administrative costs, so we can keep the cost of our services affordable. Here's how it works:

- You will be asked for a credit card or debit card when you check in
- We will store this account number in your medical record
- Your card will only be charged once the Explanation of Benefits is issued by your insurance company

We are contracted with numerous insurance companies, and will file your claim as a courtesy to you. Because every plan has different stipulations regarding payment for services received, it is your responsibility to understand your benefits. If you do not inform us of any special requirements in your insurance contract, such as referrals or pre-authorization for treatment, and your insurance company does not cover these charges, we will bill you directly. This is also our policy in the event of claim refutations, such as medical necessity or pre-existing condition denials.

Please note: You will be made aware of any outstanding balance on your account through e-mailed statements and mailed statements. However, after 90 days of nonpayment you will be sent to our collections agency. If you are sent to collections, there will be a $50 processing fee as well as a fee of 20% of your balance added to your original balance.

**Please be advised that when we verify your benefits, we are dependent upon the information given to us at that time. However, you are ultimately financially responsible.**

**Patient/Guardian Signature: _____Date:_____**

**NOTICE OF BALANCE PAYMENT**

**Please read the following Notice of Balance Payment and initial below:**

You will be required to make payment, or payment arrangements, on any outstanding balance you may have accrued prior to scheduling a follow-up appointment with us.

**Patient Initials: _____**

**NOTICE OF ALLOWABLE FEES**

**Please read the following Notice of Allowable Fees and initial below:**

The fee ranges listed below are an estimation of the charges generally allowed by insurance companies. Please be aware that if you have not met your deductible, you may be responsible for the full amount of the charges allowed by your insurance company. *These fees are only an approximation, and they do not necessarily represent actual allowed amounts by an insurance company.*

New patient appointment: $150-300
Allergy skin testing: $450-1,100
Asthma testing/spirometry: $65-$150
Asthma testing/exhaled nitric oxide measurement: $15-$45

**Patient Initials: _____**