# ALLIED HEALTHCARE ASSOCIATES
# FINANCIAL POLICY

Thank you for choosing Allied Healthcare Associates (AHA). We are committed to providing you with the very best care possible. The following is a statement of our financial policy, which outlines both patient and practice financial responsibilities. Please read and sign below.

**MEDICARE**
Allied Healthcare Associates accepts assignment for Medicare. We will file any secondary insurance claims as well. You may be asked to sign a waiver for tests/procedures not covered by Medicare. You have the right to refuse these tests/procedures. If you do refuse, you will be asked to sign a waiver stating that you have refused these tests/procedures.

**ALL INSURANCE CARRIERS**
Claims will be filed with your insurance company. You will be responsible at the time of service for all co-pays, co-insurance, deductibles, and services not covered by your plan. Financial responsibility for services rendered rest with the patient, regardless of any insurance coverage. Although we will do everything possible to facilitate reimbursement from your insurance company, we cannot guarantee payment of your claim. Insurance follow-up is the responsibility of the patient. If the claim becomes the patient's responsibility, the claim must be paid within 20 days.

**SELF-PAY PATIENTS**
As a courtesy to our uninsured, self-pay patients, we offer a 20% discount. Full payment is due at the time of service. We accept cash, checks, Visa, or MasterCard.

**CHANGE OF INSURANCE**
It is your responsibility to provide our office with any change of insurance information. Claims denied due to "untimely billing" as a result of patient not providing us with correct insurance information will become the patient's responsibility.

**MEDICALLY NECESSARY SERVICES**
The insurance company may deny some services as not medically necessary. The patient is responsible for all billable services.

**STATEMENTS**
Regardless of any claim pending, if there is an open balance, a statement may be sent to you once per month. Any patient balances remaining after insurance payment must be fully paid within 20 days.

**COLLECTIONS AND NSF CHECKS**
Delinquent accounts will be forwarded to our collection agency. A collection fee of $25 will be added to the unpaid balance to recover our costs for collection. In the event litigation is necessary, you will be liable for court costs and attorney fees as well. There is a $30 fee for all returned checks.

**CANCELLATION POLICY**
Any appointment cancelled within 24 hours of the scheduled appointment time will be subject to a $50 cancellation fee. We promise to respect your time by not double-booking our patients or scheduling patients too close together. In return, we ask that you are respectful of our time by canceling appointments only when necessary and with as much notice as possible.

**MEDICAL RECORDS**
Your medical records will be kept in the strictest confidence. If you request a copy of your medical records for yourself or to be sent to another physician, a written authorization will be required. Our copy service (Diversified Medical Copy Service) will notify you regarding processing fees and any additional costs. Only the records requested will be forwarded. Should you bring another physician's records to us, you may want to consider keeping a copy for yourself.

I hereby give my consent for AHA to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations.

With this consent, AHA may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory and/or other pertinent results. AHA may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards and patient statements, as along as they are marked "personal and confidential."

By signing below, I acknowledge that I have read and understand the information presented above and wish to receive diagnostic and treatment services from AHA. I agree to fully be responsible for any and all charges for services rendered and not covered by my insurance plan. Failure to sign this document may result in termination of care.

Print Name:_____

Signature:_____ Date:_____