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KERN ALLERGY MEDICAL CLINIC FINANCIAL/OFFICE POLICY:

Our goal is to provide outstanding allergy care for our patients as well as foster good physician/staff patient relationships. Please do not hesitate to ask a staff member if you have any questions.

Insurance Coverage:

- As a courtesy Kern Allergy will verify your coverage and bill your insurance carrier on your behalf. However, **you are ultimately financially responsible for the payment of your bill.**
- It is your responsibility to be aware of your insurance eligibility and coverage including but not limited to:
  - Copay amounts
  - Applicable coinsurance amounts
  - Deductible amount
  - Authorization requirements
  - Exclusions
  - Limitations
  - Policy previsions

  Please refer to your summary of benefits from your insurance carrier or contact your insurance carrier directly if you have any questions regarding your coverage.

- Kern Allergy will attempt to verify that your coverage is valid at the time of your visit(s) however, if your coverage is not in effect at the time of your visit(s), th**e financial responsibility is yours.**
- Kern Allergy will make every effort to determine the amount of applicable copayment, co-insurance or deductible that you owe prior to your appointment based on the information available from your insurance carrier.
- **YOU ARE FINANCIALLY RESPONSIBLE FOR PAYING ALL COPAYMENTS, CO-INSURANCE AND DEDUCTIBLES DUE AT THE TIME OF SERVICE.** After your insurance carrier processes a claim, if they determine that you have a greater financial responsibility, you will receive a bill in 30 days of receipt. If your insurance carrier determines that you owe less, any overpayment will be refunded.
- You are responsible to provide correct and current insurance information, including eligibility. Otherwise you are financially responsible for payment of any claims affected.
- You are responsible for responding to any request from your insurance carrier for additional information. Not responding to these requests in the claim(s) being denied and you will be financially responsible for payment of any claims affected.

Medicare/Medicare Supplement

Your physician may or may not be a participating Medicare/Medicare Advantage provider. However, if your physician does participate in your Medicare plan we will bill as followed:

- If you have Medicare, we will bill Medicare. However, you are responsible for any amount that is not covered of that Medicare does not pay.
- If you have a Medicare HMO or PPO we will bill your insurance carrier. However you are responsible for applicable copayments, co-insurance, deductibles and any amounts that your insurance does not cover or does not pay.
- If you have a Medicare supplement plan, we will bill Medicare and your supplement plan. However, you are responsible for any amount that is not covered or paid by Medicare or your supplement plan.

Other Fees

- Copy of medical records *($15 for the first report; 10¢ per sheet thereafter)*
- Form completion fees
- School Forms
- Charge for Return checks

Initial the following:

_____ I understand that I am responsible for paying all copayments, coinsurances and outstanding deductibles in full at the time services are received and if I'm a self-pay patient payment in full will be required at the time services are received.

_____ I understand that I am ultimately financially responsible for payment of all services received. I have read and understand my financial responsibilities.

_____
Name of Patient (Please Print)

_____
Signature of Patient or Guardian

_____
Date