Tonny Tanus, MD
Eric J. Boren, MD
Board Certified Adult & Pediatric

OFFICE FINANCIAL POLICY

Our goal is to provide and maintain a good physician- patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do no hesitate to ask a member of our staff.

Patient Registration

1. A copy of your current insurance card, drivers license and verification of your address is required **at every visit**. You are responsible for ensuring your address and insurance on file are correct. You are responsible for any unpaid balances or fees that arise if this information is not updated.

Cancellations & No Show Policy

1. Missed appointments not only impact you, but other patients waiting to be seen. If you are unable to keep your appointment, we require 24 hours' notice to cancel so we can open this time up for other patients to schedule. If you do not call within 24 hours you are subject to
   $30 fee for any missed appointment
   $50 fee for any missed procedure appointment (Skin Test or Pulmonary Function Test)

Insurance Coverage

1. As a courtesy, Kern Allergy will verify your coverage and will file insurance claims to your primary and secondary insurance carrier. If the secondary does not cover the balance owed from the primary insurance, you are responsible for any balance on the account.
2. Patients are expected to pay for all estimated co-payments, deductibles, and coinsurances at the time of service. If you are unable to pay your co-pay and any other patient responsibility at the time of service, you will be asked to reschedule.
3. If you have a Deductible exceeding **$500**, you are required to provide credit card information (*see attached form*). Otherwise services will be paid out of pocket.
4. If our physicians do not participate in your insurance plan, payment in full for your visit is due at the time of your visit.

Insurance Authorizations

1. It is your responsibility to understand your insurance benefit plan, and to know if a written referral or authorization is required to see the specialist. Often a preauthorization is required prior for procedures. We strongly urge you to contact your insurance company prior to your appointment for detailed benefit coverage, policy limitations, and non-covered service.

Payment

1. I f payment arrangements have not been made with our billing department prior, patients with outstanding balances over *90 days* with any unpaid portions will be billed to your credit card or debit card on file. Appointments will not be scheduled and will not be provided refills until balance is paid in full.
2. A **$50.00** fee will be charged for any checks returned, along with any bank fees included.
3. If you are requesting a copy of your medical records, there will be a $**15.00** fee for the first report; **10 ¢**per sheet thereafter.
4. Should you have forms that need to be completed and signed by the Physician you may be subject to a **$25.00** fee for the first page and **$5.00** for any additional forms.

Minor Patients

1. Patients under the age of 18 must be accompanied by the parent or guardian. *(Unless consented)*
2. The parent who consents for treatment will be the responsible party on the account and is responsible for all charges regardless of divorce or separation decree.
3. We request patients age 18 or older covered under their parent's insurance to sign an authorization allowing Kern Allergy Medical Clinic to contact parents regarding insurance and billing issues.

Termination/ Discharge from Practice

The following scenarios may jeopardize the patient/physician relationship in which Kern Allergy Medical Clinic will terminate and discharge the patient from the practice. The patient will be sent a letter of discharge.

- Noncompliance/ Abusive Patient
- Excessive no shows
- Failure to meet financial obligations
- Profanity
- Threats of social media retaliation

I have read and understand Kern Allergy Medical Clinic Financial Policy and agree to comply and accept responsibility for any payment that becomes due as outlined previously.

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Name of Patient (Please Print)

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Signature of Patient or Guardian

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Date