

**Allergy and Asthma Affiliates Inc.**  
**SRINAGESH PALUVOI, M.D**  
**Diplomate, American Board of Allergy and Immunology**

**OFFICE FINANCIAL POLICY**

Whether you are new to Allergy and Asthma Affiliates, or we have had the pleasure of serving you over the years, we would like you to be aware of our financial policies.

**Registration at each visit our receptionist will verify and update your demographic information and insurance coverage and may periodically ask you to complete a new registration form to insure our information is accurate. Please bring your insurance card at each visit.**

**Insurance:** Allergy and Asthma Affiliates participate in Medicare, Medicaid, and commercial insurance plans in the Northern VA area but cannot know the details of the coverage and benefits for your policy. Therefore, you will need to be familiar with your policy and know what is required to access medical care. Your insurance may have the following requirements:

- Referral from your primary care physician authorizing your visit with our doctor, done either by a specific form or by a tracking number assigned to your visit. (If your insurance card has a physician's name on it, that physician must authorize your care by a specialist.)
- Co-pay that must be paid at each visit
- Annual deductibles that apply
- Specific hospitals, x-ray facilities, and clinical laboratories that must be utilized for these services.

If you are unsure of what you need, contact your insurance representative or primary care physician before your visit

**A further note about Referral Authorizations:** if your insurance policy requires this referral, **it is your responsibility to make sure we have authorization prior to being seen by the doctor.** Unless you have a medical emergency, if we do not have a referral authorization for your visit and you are unable to obtain one, the visit will be rescheduled. While this may seem harsh, it is for your protection as much as ours, as some insurance plans will not pay for any tests or treatment that result from an unauthorized initial visit. If you have a second insurance company, please consider whether that insurance company may require prior referral authorization for the services; if so, and none has been obtained, they will deny payment and you will be responsible for the amounts they might have otherwise paid on your behalf.

**Patient responsibility balances.** You will be responsible for:

- Services not covered by insurance
- Co-pays and balances remaining after your insurance company has paid, including deductibles and co-insurance (percentage that is your obligation)
- Balances that remain unpaid 60 days after they have been filed with your insurance company but we have received no payment or response

Payment in full is expected within 30 days from your first statement advising you of the balance due. Self-pay and services not covered by insurance. If you do not have insurance or we are not contracted with your insurance plan, you will be expected to pay at the time of service, or, in some instances, prior to service.

**Payment methods:** For your convenience, in addition to cash, or personal check, we also accept VISA, Master card, Discover, and American Express cards. Please be aware that checks returned for insufficient funds will result in a **\$25.00** fee being added to your account.

**Medical Care to Minors:** If both parents have insurance, the insurance of the parent whose birthday falls first in the calendar year will be considered primary for the child, and the other parent's insurance will be secondary. When the parents are divorced, we will consider the parent or guardian who presents a child for care to be the responsible party for payment of services, regardless of financial responsibility established in a divorce decree.

**Cancellation Fees:** if you are unable to keep your appointment, please let us know at least 24 hours in advance to avoid a **\$50.00** fee; because this time is just reserved for you. We appreciate your courtesy.

**Acknowledge and Authorization:** I have read understand, and agree to the above financial policy. Regardless of my insurance status, I am ultimately responsible for payment for any professional services rendered. I authorized the release of any medical information necessary to process a claim for benefits under my policy and assign payment of my insurance benefits to Allergy and Asthma Affiliates. If my account should become delinquent, I agree to pay the costs of collection, including legal fees and court costs.

Signature \_\_\_\_\_  
Patient and/ or responsible party

Date \_\_\_\_\_