Mt. Lebanon Allergy Associates, Inc.
Mina Patel, M.D.
2040 English Turn Drive
Presto, PA 15142

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT AND NOTICE OF POLICIES

Your signature below forms a binding agreement between Mt. Lebanon Allergy Associates, Inc., Mina Patel, MD (the provider of services) and the Patient who is receiving services, or the Responsible Party (when applicable). The Responsible Party is the individual who is financially responsible for payment of bills.

For patients without insurance benefits, payment is due in full at the time of service.

MEDICAL INSURANCE: PATIENTS ARE RESPONSIBLE FOR CONFIRMING THEIR OWN INSURANCE BENEFITS. IT IS ALSO YOUR RESPONSIBILITY TO VERIFY THAT MT. LEBANON ALLERGY ASSOCIATES, INC., MINA PATEL, MD IS AN APPROVED PROVIDER UNDER YOUR PLAN (OR "IN NETWORK"). We have contracts with many insurance companies, and we will bill them as a service to you. Please be aware, insurance companies do not guarantee payment. Our office can only **ESTIMATE** the approximate percentage or amount that your insurance may pay. Some or perhaps all of the services may not be considered reasonable and necessary under your insurance plan. In this instance, as the Responsible Party, you are responsible if your insurance company declines to pay for any reason.

The Patient or the Responsible Party must:

- Inform Mt. Lebanon Allergy Associates, Inc., Mina Patel, MD of the current address and phone number for the patient and the Responsible Party
- Inform our office immediately of any change in your insurance coverage
- Contact your medical insurance company to confirm coverage and in-network status
- Verify at each visit your information is correct
- **Verify at each visit your balance is $50.00 or less. Services will not be provided if your balance is over $50.00 without a current payment plan in place, with regular monthly payments.**
- Pay any required copay or portion your insurance will not cover at the time of visit

PAYMENT ARRANGEMENTS: Payment plans are available, please speak with one of our staff members to discuss payment plan arrangements.

RETURNED CHECK POLICY: If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), or Account Closed (AC), the Patient or Patient's Responsible Party will be responsible for the original check amount in addition to a $30.00 Service Charge. Once notified by our office, if payment in full is not made within 15 days by the Patient or Responsible Party, the account may be turned over to our collection agency.

COLLECTION FEES AND EXPENSES: You understand and acknowledge that you are responsible for any fees or expenses, including reasonable attorney's fees and collection agency fees incurred by Mt. Lebanon Allergy Associates, Inc., Mina Patel, MD, in collecting any balances due under the terms of this Agreement. Fees will be in addition to the balance due.

PRE-AUTHORIZATION AND REFERRALS: Many insurance carriers require a referral from your Primary Care Physician (PCP) before you receive care from a specialist. It is YOUR responsibility to obtain a referral or prior authorization if your medical coverage requires it.

NO SHOW/MISSED APPOINTMENT POLICY: We request notice of at least 24 hours for cancellation of appointments. We understand that sometimes last minute cancellations are unavoidable. If this is the case, please call the office as soon as possible. Our schedule fills up quickly and this will allow us to reallocate those slots to other patients. Patients may be ***dismissed from the practice*** for the following:

- **2 missed appointments**
- **3 canceled appointments**
- **3 rescheduled appointments within 24 hours of original time**

Initial: _____

NON-COMPLIANCE: Repeat of ***non-complaint behavior*** may also result in being dismissed from the practice.

Initial: _____

NOTICE OF NON-COVERED SERVICES: The doctor may recommend a procedure that is not a covered benefit with your carrier. Insurance carriers will only pay for services that are covered by your particular plan and they consider medically necessary. Some services may not be a covered benefit; however, the doctor will not base your plan of care on insurance coverage. All non-covered services must be paid in full at the time of service. In cases where your insurance company denies payment for services rendered, you are responsible for payment of your treatment.

DIVORCED/SEPARATED PARENTS: Please be advised that in the event of any dispute between parents/guardians about who will be responsible for amounts due, etc., the party initiating the treatment and signing this PATIENT FINANCIAL RESPONSIBILITY AGREEMENT AND NOTICE OF POLICIES is deemed financially responsible for the account. Failure to arrive at your appointment with the estimated balance due in full will require us to reschedule. We do not get involved in such disputes.

By signing below, you agree to accept FULL FINANCIAL RESPONSIBILITY as a patient who is receiving services or as the parent/guardian for the patient. You authorize payment of benefits to Mt. Lebanon Allergy Associates, Inc., Mina Patel, MD. Your signature verified that you have read the above, have had the opportunity to ask and have answered any questions, understand your responsibilities, and agree to these terms.

_____

Print Name

_____ _____

Signature of Patient / Parent or Guardian of Patient **Date**