



Allergy, Asthma & Immunology of the Rockies, P.C.

Robert McDermott, M.D.

DIPLOMATE - THE AMERICAN BOARD OF ALLERGY AND IMMUNOLOGY

www.allergyoftherockies.com

2520 S. Grand Avenue Suite 209
Glenwood Springs, CO 81601

Appointments: 970-947-0600
Fax: 970-947-0601

OTHER LOCATIONS:

711 EAST VALLEY ROAD SUITE 201A
BASALT, COLORADO 81621

377 SYLVAN LAKE ROAD SUITE 220
EAGLE, COLORADO 81631

Financial Policy

Welcome to Allergy, Asthma, & Immunology of the Rockies. It is important that all our Policies are fully understood by you to ensure you receive continuous, experienced and timely health care. Please read this policy and acknowledge your understanding and agreement with your signature. We invite you to ask questions and/or clarifications if you have any. Thank you.

I agree that:

AAIR, PC. will bill my insurance provided all the necessary information is given to the clinic at the time of service. This includes a valid, current insurance card. If this is not available, I will be asked to pay all charges for the date's visit before I leave the office. AAIR, PC will ask to see your insurance card at every visit to ensure that we have all the proper billing data and that the card is current.

If my insurance company does not submit payment within 30 days, I understand I will be responsible for any and all outstanding balances. I am aware that my insurance carrier, rather than my physician, may deny some services for the reason of "not medically necessary" or "non-covered services, therefore, I will become fully responsible for payment of these services.

If I have asked for an estimate of cost for my visit, this will be given as closely as possible. However, since AAIR, PC is not aware of the exact number of skin tests, level of care etc. that will be needed until the physician has seen the patient; this is considered only as an estimate and not an exact charge quote.

I assume all responsibility for the deductible costs of my insurance plan. These costs will be billed to me immediately by AAIR, PC when my insurance plan states that these are my costs and not theirs.

AAIR, PC will make all attempts to collect payment from the insurance carrier; however, I am ultimately responsible for all costs associated with my visit. Though insurance coverage may be carried, it is not a guarantee of payment. I understand that if my insurance company fails to pay AAIR, PC, any remaining balance will be my financial responsibility and will be paid in full upon receiving a statement of balance. I will pay this balance within 15 days or contact AAIR, PC to make financial arrangements. I agree to allow AAIR, PC to telephone me at any of my phone numbers given to AAIR, PC to discuss any issues regarding payment of my account. A late fee of \$20.00 will be assessed if my account is not paid in 45 days. All bills must be paid in full within 57 days or my account may be sent to an outside collection agency. Once this is done, I must deal directly with the collection agency and not AAIR, PC as it is out of their hands to do anything with my account. This agency will add the appropriate fees for collection if my account is sent there. At this time AAIR, PC will cease giving care to me and my dependents.

Signature of Patient (or Legal Guardian)

Date