ALLERGY & ASTHMA
CONSULTANTS OF MONTANA
MICHAEL C. DICELLO, MD
CINDY K. FEDDES, FNP

FINANCIAL POLICIES

We require a copy of a photo ID and any insurance cards that are to be billed for service rendered.

- **PAYMENT—** Our office will attempt to verify your insurance benefits prior to or during your appointment so that we may collect based on your benefits. **Payment is expected at the time of your visit**. Payment will include any unmet deductible, co-insurance, co-pay amount, or non-covered charges from your insurance company. We accept cash, check, Visa, MasterCard, Discover, American Express, and Care Credit.

- **INSURANCE—** Our practice participates with many health insurance companies. Our office will attempt to file all insurance claims based on information provided by you. **Please remember that we are not a party to your insurance contract and ultimately you are fully responsible for a complete payment of the medical charges.** It is your responsibility to check with your insurer's member benefits department about your coverage prior to your appointment. You are responsible for obtaining a properly dated referral if required by your insurer and are responsible for payment in full if your claim is rejected.

- **PAST DUE ACCOUNTS—** Any account older than 90 days will be subject to late charges. Failure to pay, or failure to complete payment within a year (regardless of payments being made), may result in the account being turned over to a collections agency. In the event your account is turned over to a collection agency, you will be responsible for all costs and fees associated with collection, including without limitation, attorney's fees.

- **LATE CHARGES**—A finance charge of **15.99%** annually will be applied to patient balances of 90 days or older. Rates may be subject to change. We offer short-term payment plans to assist with large balances. Please reach out to our billing manager if you have any concerns about paying your balance in full to avoid late charges.

- **NO SHOW/CANCELLATION POLICY—**We ask that you provide our office with at least 24 hours advanced notice of any appointment changes or cancellations. **If you do not attend your scheduled appointment ("no show") or fail to provide us with 24 hours advanced notice, you will be responsible for a $25.00 fee**. This is not an amount that will be billed to insurance and it must be paid prior to your next appointment.

- **RETURNED CHECKS—**will incur a $30.00 service charge. You will be asked to bring cash or a money order to cover the amount of the check plus the service charge.

- **MINOR PATIENTS (under the age of 18) —** The adult accompanying a minor assumes responsibility for payment of the minor's account. If there is a financial arrangement with another or a different adult, we need written authorization from the financially responsible adult that he/she consents to payment of services for the minor.

- **ADULT PATIENTS (age18 and older) —** If an adult other than the patient is assuming financial responsibility, we will need written authorization from the financially responsible adult that he/she consents to payment of services.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE POLICIES

PATIENT SIGNATURE_____ **DATE**_____
(GUARDIAN SIGNATURE IF PATIENT IS UNDER 18)

PRINTED NAME OF SIGNER _____