Allergy & Asthma Center of Tuscaloosa, PC

535 Jack Warner Pkwy NE, Suite C
Tuscaloosa, AL 35404
205-553-2252
Website: **allergytuscaloosa.com**

EXPLANATION OF PAYMENT POLICY AND STATEMENT OF FINANCIAL RESPONSIBILITY

We appreciate you choosing our practice for your allergy and asthma care. We believe it is in your best interest to understand our charges and payment policies prior to your visit.

As a courtesy to our patients, we will file claims for our services with most commercial insurance carriers. The exceptions to this are "Actice Duty" Champus and any commercial carrier who does not provide adequate information to us for filing. If your insurance company responds and does not pay for the services due to a co-pay, deductible portion, non-covered charges, or any other reason, determined by your policy, then the charges will be billed to you and payment will be expected at the time the first statement is rendered.

At the time of service you will be responsible for your co-pay determined by your insurance. If you do not have insurance which covers your visit, full payment is expected at the time of service.

As our patient, we want to provide you the best possible care. There may be certain services that the physician feels are necessary for the maintenance of good health that are not covered by your insurance. You will be expected to pay for those services in full. Let us reassure you that the physician will only order tests he believes are necessary for your treatment and care. We will make every effort to notify you of any services we suspect may not be paid by insurance. If you have any questions regarding covered services, please ask.

Some services that may not be covered by your insurance are:

VACCINATIONS
ALLERGY SKIN TESTING AND ALLERGY CHALLENGES
ALLERGY SHOTS
PULMONARY FUNCTION TESTING
DIAGNOSTIC LAB TESTING
ALLERGY SERUM

PLEASE READ AND SIGN BELOW AS INDICATED:

INSURANCE AUTHORIZATION AND AGREEMENT: I hereby authorize the ALLERGY & ASTHMA CENTER OF TUSCALOOSA to furnish information to my insurance carriers concerning my illness and treatment and I hereby assign the physician(s) all payments for medical services rendered myself or my minor dependents. I understand that I am responsible for payment of any amounts not paid by my insurance.

PAYMENT AGREEMENT: I acknowledge and agree that I am fully responsible for payment of all charges for any services rendered by ALLERGY & ASTHMA CENTER OF TUSCALOOSA and for any balance not paid by insurance when due, and I agree to pay such charges. If my account becomes delinquent for more than sixty (60), I agree to pay any collections cost, including a reasonable attorney's fee; and interest at 18% per annum from the due date. I waive any right I may have according to the laws of the State of Alabama, or any other state, to claim exemptions as to personal property to this obligation.

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Guarantor Date