

Patient Name: _____ Chart #: _____
First Mid. Initial Last

Financial Agreement

- Allergy Treatment Center will submit all of your insurance and Medicare claims in a timely fashion.
- Co-payments must be paid before you see Dr. Mumneh, or you will be charged a \$10 billing fee.
- **If you have a deductible, coinsurance or limited coverage, you will be expected to make payment arrangements prior to seeing Dr. Mumneh, based on an estimate of your responsibility. (This estimate is not guaranteed. Your insurance company will determine how much you will be responsible for. pending review of the claim.)**
 - We use *Account on File* to make electronic payments automatically through your checking, credit or debit card account. Your account will not be charged until your insurance company has finalized your claim. A statement of the transaction will be sent to you promptly.
 - *If you do not wish to make payment arrangements, there is a \$10 monthly statement fee.*
- Should your insurance company require you to make any unexpected payments (i.e., we did not know that you have a deductible for certain procedures or your coverage was terminated), we will bill you once without the \$10 monthly statement. You must pay the bill in full prior to the end of the month to avoid being charged the monthly statement fee.
- **If your plan requires a referral, we will not be able to see you without one.**
 - If you wish to keep your appointment and be seen without a referral, you will be responsible for payment of our full fee at the time of service.
 - We cannot wait for referrals, although we will refund any payments you have made if you can provide a valid referral within a reasonable time after your appointment.
- If we do not receive payment from your insurance company within 60 days after we submit a claim, you will be responsible for payment of all charges. Should we receive payment from your insurance company, we will send you a refund.
- If we do not participate in your insurance plan, you must pay in full at the time of service.
- Your health insurance coverage is a contract between you and your insurance company. **You are ultimately responsible for payment of your bill.**
- If you do not have health insurance, we expect full payment at the time of service, unless prior arrangements have been made.
- Past due balances must be paid in full before future appointments are made.
- All account balances must be paid in full within 60 days from the date of service, unless you have made formal payment arrangements with our office.
- Delinquent accounts, for which payment has not been received within 60 days, will be forwarded to a collection agency. We will charge you a collection fee of \$60 or 30%, whichever is greater.
- **We expect payment from the parent/guardian who accompanies a dependent minor to our office.** The accompanying parent/guardian will be considered the responsible party. We will not bill a non-custodial parent, even though this may be a part of a divorce agreement. Our office is not part of divorce agreements between parents. We will be pleased to provide a paid receipt for services rendered.
- Failure to cancel appointments at least 24 hours prior to the appointment will result in a \$25 charge.
- Returned checks are subject to a \$25 charge.

Who is the person responsible for payment? If the patient is a child, this person must be the accompanying parent

Name: _____ Birth Date: _____
First Middle Last

Home Address: _____ Phone: () _____

City: _____ State: _____ Zip: _____ Work Phone: () _____

Social Security # _____ (not necessary if you put your credit card on file)

Signed: _____ Date: _____

Patient Name: _____	Chart #: _____	
First	Mid. Initial	Last

**Consent to the Use and Disclosure of Health Information
for Treatment, Payment or Healthcare Operations (TPO)**

- I understand that as part of my healthcare, Allergy Treatment Center of New Jersey PC (ATCNJ) originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this protected health information (PHI) serves as:
 - a basis for planning my care and treatment.
 - a means of communication among the many health professionals who contribute to my care,
 - a source of information for applying my diagnosis and treatment information to my bill,
 - a means by which a third-party payer, such as an insurance company, can verify that services billed were actually provided, and
 - a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.
- I understand that I have the right to review ATCNJ's *Notice of Privacy Practices*, which provides a more complete description of information uses and disclosures. This notice is available on our website, www.allergytreatmentcenter.net, or at our offices upon request.
- With this consent, ATCNJ may communicate with me, by telephone, voicemail, mail or email in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, patient statements, clinical care, including laboratory test results, among others.
- I understand that I have the right to request restrictions, in writing, as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that ATCNJ is not required to agree to the restrictions requested.
- I understand that ATCNJ reserves the right to change their notice and practices at any time. A copy of the revised notice will be posted on our website.
- I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

By signing this form, I am consenting to allow ATCNJ to use and disclose my PHI to carry out TPO.

Signature of Patient or Legal Guardian

Date

Print Patient's Name

Print Name of Legal Guardian, if applicable

Appointment Confirmation Preferences

We are now using a service for appointment confirmations. Through this service, you may choose to receive our request to confirm your appointments:

- on a telephone (or voicemail),
- via text message on your mobile phone or
- by email

You will be able to respond automatically with all methods of communication. You will also have the option of receiving the messages in Spanish or Hindi.

Please rank, from 1 to 3, the following means of communication (for appointment confirmation purposes only).

NAME: _____

___ Telephone: _____

Phone calls will be made between 6 and 8 pm. If the system leaves you a voicemail or a family member answers and doesn't respond, **YOU MUST CALL US** to confirm.

___ Text Message - Mobile phone: _____

Some cell phone companies block our text messages. If so, we may also contact you by phone.

___ Email: _____

Please circle your language preference for phone messages. Please choose the option best for the person who will answer the phone:

English Spanish Hindi

Thank you! We appreciate your cooperation.

