Financial Policy

Please review this information and sign at the end of the document. By signing this document, the patient/responsibility party is accepting financial responsibility for all services provided.

Colorado Allergy and Asthma Centers (CAAC) will bill your insurance as a courtesy if the company is within the United States. We may provide an estimate of what your insurance company may pay. The insurance company makes the final determination of your eligibility and benefits.

It is your responsibility to notify our office of any patient information changes including address, name, and insurance information.

Insurance Accounts

1. I (patient or financially responsible party) will disclose all insurance information including primary and secondary insurance at the time of service. Failure to provide complete insurance information may result in my responsibility to pay the entire bill.
2. I agree to pay any portion of the charges not covered by my insurance within 10 days of the statement date. If CAAC is out of network with my insurance company, I will be responsible for any charges above what is paid by my insurance up to the CAAC set fee amount. If my insurance pays me directly, I agree to forward the payment to CAAC immediately.
3. I am responsible for any co-payments, co-insurances, deductibles, plus any balance due on non-covered services not paid by my insurance at the time of service. Payments are required within the state's time limitation for paying healthcare claims. The co-payment, co-insurance or deductible requirement cannot be waived. We accept cash, check or credit cards.

Self-Pay Accounts

If you do not have insurance or you choose to not utilize your insurance, we offer a self-pay discount of 25% if payment is received in full at the time of service. Self-pay accounts are for all services for the entire year, or until new insurance is initiated due to a qualifying event.
No Exceptions.

Referrals

1. I am responsible for obtaining a referral, if required by my policy.
2. I understand if I fail to obtain the referral and/or preauthorization there may be a lower payment or no payment from the insurance company. I will be responsible for the balance due.

Missed Appointments

I understand I may be charged a fee of $75.00 if I miss or cancel an appointment within 24 hours of the scheduled appointment.

Returned Checks

I understand I will be responsible for a fee of $35 for a returned check. This will be applied to my account in addition to the insufficient funds amount. All future payments must be paid with a debit/credit card or cash.

Medical Record Copies

I understand I may be responsible for a fee that follows Colorado Department of Health and Environment standard for requesting a copy of my health records.

Minor Patients

1. By signing this document, I (the parent, guardian) accept financial responsibility for all services provided by CAAC, regardless of who is the subscriber of the insurance policy.
2. I understand as the adult (parent, guardian) accompanying a minor, I am responsible for charges at time of service (such as co-payment or deductible).

A divorce decree does not determine which party Colorado Allergy and Asthma Centers, P.C. will bill for medical services. Divorce decrees are only binding upon the two parties who made the agreement.

Payments

1. I understand that I am requested to put a credit, debit or HSA card on file. This information is kept strictly confidential and will only be used for payment of fees to CAAC. The card on file will not be charged until the insurance company has reviewed the claim. By processing insurance first, patients will know their exact out-of-pocket responsibility. After the insurance company has completed processing the claim, I will receive an email informing them of the actual amount owed. The email will explain that the card on file will be charged in 3-5 days unless I contact the billing office at 720-858-7550.
2. I understand the Financial Information may be provided to the financially responsible party (Guarantor), Subscriber, or the party paying the bill.
3. I understand the financially responsible party (Guarantor) is responsible for payments.
4. I understand upon default, I am responsible for 24% per annum interest, cost of collections, and attorney fees, even if no lawsuit is filed.
5. For patients receiving allergy shots: I understand if I have a past due balance of more than $100, my antigen will not be mixed until the debt is paid.

Extended payment arrangements are available if needed. Please contact an Account Manager in our Patient Finance Office at 720-858-7550 to discuss payment options.

Please call our Patient Finance Office at 720-858-7550 with any questions or concerns.

I have read and understand the policies above and agree to this Financial Policy.

_____ _____

Patient's Printed Name Date of Birth

_____ _____ _____

Financially Responsible Party (PRINT) Financially Responsible Party Signature Date

_____ _____

Witness Signature Date