GEIST CENTER FOR ALLERGY, ASTHMA IMMUNOLOGY, PC
8150 Oaklandon Road, Suite 119 · Indianapolis, Indiana 46236
t e l 317.826.5440 · fax 317.826.5463 · www. g e i s t a l l e r g y.com

Patient Name: _____ **Date of Birth:** _____

Office and Financial Policies

Our office appreciates your trust and confidence in making us your health care provider. Payment for your care is considered part of your treatment program. Questions regarding our policies should be directed to the office manager/medical assistant. If you are unable to comply with the policies in this statement, please let us know prior to receiving treatment.

The following is a statement of our policies that we require you to **read and sign prior to any treatment.**

- All patients must complete our patient and insurance information sheets prior to seeing the physician. If these forms are not completed, you may be asked to reschedule your appointment.

Insurance Filing Notification

- If you do not have insurance, or any ALLERGY BENEFITS- payment is expected in full at the time of service. You can set up payment plans, if needed.
- We file our insurance claims electronically to insure proper filing. We will file claims for the services rendered in our office. **However, please keep in mind that it is your insurance contract, and we look to you for payment, not your insurance company. All balances are due within 30 days of the statement date unless payment plans are set up.**
- Copayments, coinsurance and deductibles are to be made at the time of service. You are responsible to pay your portion.
- We are enrolled in several managed care programs. The specifics of each plan vary greatly even within the same insurance company. If you do not inform us of any pre-authorization requirements in your contract or NO ALLERGY BENEFITS, and we subsequently treat you without the necessary information, we will have no choice but to bill you directly for the charges.
- Medicare: We are participating in the Medicare program. We will submit your claims to Medicare for you. Medicare will pay its share of the bill directly to us. You will be responsible for annual deductibles, coinsurance and copayments.

New Policy as of 03/29/2016

Appointments and Cancellations

- All patients including those receiving allergy shots are required to check in **PLEASE ARRIVE 15 minutes** prior to scheduled time. As a service to our patients we will attempt to make a reminder call. By giving your cell # you consent to receive calls at this #. Our auto system will also send texts to confirm appointments. We require 48 hours if you need to cancel an appointment. You may leave a message on our voicemail. This will allow us to use this time for another patient.
- A $45 charge will be added to your account if you fail to call to cancel or reschedule within the given time.
- If 3 appointments are missed our professional relationship will be in jeopardy, you can be terminated and you will need to seek treatment from another provider.
- In event of severe weather please call the office for delays or closings. Please call office phone for messages on delays or closures.

Fees for Additional Services

- Record Copying: Requests for copies of patient medical records will be subject to a fee as authorized by Indiana Law. If records are to be mailed, there will be an additional postage charge.
- There is a $10.00 charge to complete forms for school and a $25.00 to complete forms for insurance companies or FMLA (Family Medical Leave Act) forms.

Treatment of Minors: The parent or legal guardian who brings a minor to the office for treatment shall be responsible for all medical bills incurred at that time.

Agreement to Financial and Office Policies: I hereby agree to pay Geist Allergy, Asthma & Immunology, PC the charges for all medical services rendered. In the event that I fail to pay the fees as agreed, I understand I will be responsible for all attorney fees, court costs & collection fees that may result from my failure to pay.

I acknowledge receipt of this facility's Notice of Privacy of Practices. (Available online or in our office)

I acknowledge that I have read and agree to this Patient Consent Agreement and my questions have been answered. If I am agreeing and signing on behalf of a minor patient, I affirm that I have the legal right to consent and agree on their behalf. I understand that I can request a copy of this document.

Signature _____ **Date** _____

Patient or Guardian if patient is under 18 years old