

Allergy & Asthma Associates of Murray Hill

35 East 35 St · New York · NY · 10016 · (212) 685-4225 · Fax (212) 696-5682 · Billing (212) 685-6465

FINANCIAL AGREEMENT

I, _____, have
Patient name/guardian name

requested treatment from Allergy & Asthma Associates of Murray Hill. I have read and understood the following:

1. I am responsible for all copayments, deductibles and co-insurance as per the terms of my contract with my insurance carrier.
2. **All copayments must be paid at the time of service.** This includes multiple copayments for testing (if required by my insurance carrier) as well as predetermined coinsurance (i.e. for allergy injections.)
3. I am responsible for obtaining any and all required referrals for service.
4. I am responsible for all non-covered services. The office will do its best to inform me of any service that will not or may not be covered. However, I understand that benefits are not determined by my insurance carrier until *after* the claim is submitted, therefore, there is no guarantee of payment by my insurance carrier.
5. I am responsible for updating my health insurance information with the office any time the information changes/terminates/new coverage begins. The office will submit my medical claims for me as per the terms of the contract with my insurance carrier.
6. The office is restricted to a “timely filing” period. I understand that I must provide my health insurance carrier information in a timely fashion, so that the claim may be paid. Any claim unpaid because I did not supply the office with my information in a timely fashion is my responsibility and I am responsible for payment.
7. Payment plans are available based on financial necessity. I understand that I must speak with the *Billing Manager* or the *Office Manager* to establish a payment plan.
8. Fees associated with allergy serum, prepared at my request or due to insurance regulations, are my responsibility. Should I choose to discontinue allergen immunotherapy or not use the prepared serum, I am still responsible for these fees, once the serum has been prepared.
9. A check returned from my financial institution is subject to a returned check fee. This fee is based on the current rates set by the office’s financial institution. This current rate may be obtained by calling the *Billing Manager*.
10. Any account balance over 60 days old is subject to collections proceedings. A \$20.00 processing fee will be assessed to an account each time a balance is turned over for collections. My account may be reported to the major credit bureaus if I do not pay this balance.

Patient Signature / Name

Guardian Signature

Date signed

James M. Rubin

Paul M. Ehrlich, M.D.
Diplomates, American Board of Allergy and Immunology

Michael G. Teitel, M.D.