Advanced Allergy & Asthma
Dr. Melissa Graham and Associates

500 S University Ave, Ste 215
Little Rock, AR 72205
501-420-1085: phone
501-420-1457: fax

Patient Name: _____ Date of Birth: _____

Patient Financial Policy

1. **ON INITIAL OFFICE VISITS:** Your initial office visit charges will be filed to your insurance company at your request, but you will be expected to pay your coinsurance and any deductible not met at the time of service.

2. **ON REVISITS:** We will file your insurance for you on revisits, but you will also be expected to pay your coinsurance and any deductible not met at the time of service.

3. **COPAYS:** You will be expected to pay your insurance copay every time you see the doctor. THIS CANNOT BE BILLED, as this is part of the contract between you and your insurance company.

4. **UNINSURED PATIENTS:** Payment will be expected at the time of service.

5. **NON-COVERED CHARGES:** You will be responsible for all non-covered charges (lab, procedures, etc.) not payable by your insurance company.

6. **FINANCIAL QUESTIONS:** Please speak with the front desk prior to being seen by the doctor if you have any questions while you are in our office. Under certain circumstances, a statement may be mailed to you, and you will be directly responsible for any unpaid balance on your account. Please refer all inquiries regarding financial services to the front desk. The doctor is here to provide your medical care, and the staff is here to help with any financial questions.

7. **CANCELLATION:** If cancellation is necessary, we require that you call at least 24 hours in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time. Missed appointments, or appointments cancelled without 24 hours' notice, will incur a fee of **$50.00**.

I request that payment of authorized insurance benefits be made on my behalf to Advanced Allergy and Asthma for services furnished me. I authorize any holder of medical information about me or my dependent to release to the insurance company any information needed to determine these benefits or the benefits payable for related services. A photocopy of this assignment is to be considered as the original. I understand that I am financially responsible for all charges whether or not covered by said insurance. This assignment will remain in effect until revoked by me in writing. I further agree to pay the cost of collection, court costs, and other reasonable fees should they be required in the event of my non-payment. (If this patient is a minor child, the parent signing this form will be financially responsible for the child. Any legal agreement, or other disagreement, between parents in a divorce must be dealt with between those parties and does not involve Advanced Allergy and Asthma.)

_____ _____

Signature of patient (or responsible party, if patient is minor) Today's Date