



ALLERGY & ASTHMA ASSOCIATES, INC. 513-793-6861  
10597 Montgomery Rd., Suite 200, Cincinnati, OH 45242  
7144 Office Park Dr., West Chester, OH 45069

### Patient Information

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_

### FINANCIAL RESPONSIBILITY AGREEMENT

Please read and sign below to acknowledge your understanding of our financial policies.

#### 1. Insurance Coverage

- I understand that **it is my responsibility** to provide accurate and current insurance and demographic information.
- I understand it is my responsibility to be sure that Dr. Sutton / Dr. Eckman are in my network.
- I authorize the release of medical information necessary to process my claims.
- I understand that **insurance verification is not a guarantee of payment.**

#### 2. Co-Payments, Co-Insurance, and Deductibles

- I understand that **all co-pays are due at the time of service.**
- Any applicable **deductible or co-insurance amounts** determined by my insurance provider will be billed to me, and **I agree to pay these charges.**

#### 3. Non-Covered Services

- I understand that my insurance may not cover all services, and I agree to be financially responsible for **any service not covered** by my insurance plan.
- I understand that there is a charge for completing forms for school/work/camp etc.

#### 4. Self-Pay Patients

- If I am uninsured or choose to self-pay, I agree to pay all fees **at the time of service**, unless other arrangements have been made.

#### 5. Billing and Payment Terms

- Statements are due upon receipt.
- **Balances not paid within 30 days** may incur late fees or be sent to a collection agency.

#### 6. Missed Appointments / Late Cancellation

- I understand that cancellations must be made **at least 24 hours** before the appointment.
- I agree to pay a **no-show/late cancellation fee of \$60** if I fail to do so.
- I understand that if I **no-show/late cancel** a New Patient appointment, I will be required to make a **\$200 deposit to reschedule.**

#### 7. Returned Checks

- I understand that a **\$40 fee** will be charged for any returned check.

#### 8. Authorization to Pay Benefits

I authorize insurance benefits to be paid directly to Allergy & Asthma Associates, Inc. for services rendered.

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### Acknowledgment and Signature

I have read and fully understand the financial policies above. I agree to comply with these policies and accept financial responsibility for all charges incurred.

Patient/Guardian Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_