STEVEN A. SUTTON, M.D. ♦ JOHN A. ECKMAN, M.D.

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.
- I understand that there is a $75 charge for FMLA, 504 Plans, Disability forms or Specialty Letters

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.

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: _____