SAINT CLAIR ALLERGY & ASTHMA CENTER

OFFICE, TREATMENT, CONSENT, AND FINANCIAL POLICY AGREEMENT

01. AUTHORIZATION FOR TREATMENT, MEDICAL HISTORY, AND PROCEDURES

I hereby agree to and give consent to be treated by Saint Clair Allergy & Asthma Center and all its physicians, its employees, and other healthcare providers. I acknowledge that no guarantees have been made to me as to the results of the diagnosis, treatment, tests, or examinations. This consent may be used for ongoing, related services. I understand the course of my treatment at Saint Clair Allergy & Asthma Center. I hereby authorize Saint Clair Allergy & Asthma Center to obtain the Medication History related to the purpose of treatment. I understand that this authorization to obtain a medication history is revocable upon written notice to the office where the original authorization is retained, except to the extent that action as already been taken on this authorization.

02. HIPAA & MEDICAL RECORD RELEASE OF INFORMATION

I give my permission to Saint Clair Allergy & Asthma Center to disclose all or any part of medical and billing records to any insurance company, third party payer (including my employer if applicable, for example in workers' compensation cases), or collection agency, which may be responsible for payment of Saint Clair Allergy & Asthma Center charges on my behalf or for collection of unpaid balances from responsible parties/responsible guarantors. I further authorize such disclosures to any of my other treating healthcare providers as needed for treatment or billing payment purposes. I am aware that Saint Clair Allergy & Asthma Center will release information as permitted by law regarding treatment, payment, and/or operations in accordance with the HIPAA Omnibus Rule. I authorize SCAAC communications regarding my treatment, payment, operations via text, email, and voicemail.

03. FINANCIAL RESPONSIBILITIES

In consideration of all services and supplies provided by Saint Clair Allergy & Asthma Center, I completely understand and fully agree that I have full responsibility to pay Saint Clair Allergy & Asthma Center. I hereby guarantee full payment for all charges. If my account is referred to a collection agency or an attorney, I guarantee payment for all collection fees and costs. I understand that the responsibility for payment may not be deferred for any reason. Saint Clair Allergy & Asthma Center may bill my insurance (s), but I and my estate remain fully responsible for full payment. I fully understand and agree to be financially responsible for full payment if any insurance determines services were not referred, authorized, or are non-covered according to my benefits. Saint Clair Allergy & Asthma Center does not deny services to any patients based on their insurance company's requirements or determinations.

- SCAAC accepts cash, personal checks, Visa, MasterCard and Discover. There is a $50.00 processing fee for all non-sufficient check funds.
- SCAAC billing structure is compliant with current year CPT. After hour or weekend servicing may be subject to additional charges.
- Deductible and/or coinsurance as per your agreement with the insurance company will need to be paid upon request or at the time of service. Unfortunately, some elective procedures cannot be scheduled until this amount is paid.
- We do participate with numerous insurance companies, meaning we have a contract with them. Copayments and/or non-covered services are required to be paid in full at the time of service. Copays are due at the time of service or your appointment will be rescheduled. Our contract with the insurance companies states that patient balances (deductibles/coinsurance) cannot be waived.
- There are some insurance companies we do not participate with under contract. You are required to pay all visits in full at the time of the visit. We will submit a claim to your insurance carrier on your behalf. Any payment from the insurance company will usually be sent directly to you. You will be responsible for following up with your insurance company regarding any potential reimbursement for the services rendered. You will be asked to pay our charges in full prior to services being schedules/rendered.

- Payment for services is due in full at the time of service if there is no medical insurance plan available. Payment is required prior to the procedure being scheduled. Please inquire with our office staff regarding payment options.
- If the insurance plan requires you to obtain a referral from your Primary Care Physician (PCP), you are responsible for obtaining the referral and presenting it at your visit. If you do not have the referral, the appointment will need to be rescheduled. This is a requirement of your insurance company. As a reminder; your PCP may require at least five (5) days to prepare the referral. Check with your doctor's office regarding their specific policy.
- I understand that if I do not present accurate, current and complete billing insurance information at the time of services, I agree to be responsible for any amounts relating to the full payment of any amount not covered by insurance. I relieve Saint Clair Allergy & Asthma Center any responsibility in the event correct information was not provided at the time of service. A copy of my insurance card (s) will be maintained to verify what was presented to Saint Clair Allergy & Asthma Center. I am aware that a non-expired photo identification is required to be on file at Saint Clair Allergy & Asthma Center as required by the Federal Trade Commission to provide proof of identity for claim submission and medical operations.

It is impossible for any medical provider to know the insurance benefits of every patient. Benefits vary based on the wide variety of policies sold to employers and patients. It is your responsibility to know your medical benefits. We will assist you if necessary; however, the ultimate responsibility of knowing your benefits rests with you.

04. PATIENT CENTERED MEDICAL HOME

Saint Clair Allergy & Asthma Center is a participant in the Patient Centered Medical Home process. The Patient Centered Medical Home is designed to meet the majority of a patient's physical and mental health care needs through a team-based approach to care. The Patient Center Medical Home model is committed to providing safe, high-quality care through clinical decision-support tools, evidence-based care, shared decision-making, performance measurements, and population health care management. Sharing quality data and improvement activities also contribute to a system -level commitment to quality. I hereby agree to participate in the PCMH processes by making sure my physician knows my entire medical history, informing my doctor of all the medications including over-the-counter medications and vitamins that I am taking at each visit, actively participating with my provider in planning my care, keeping my appointments as scheduled, adhering to the action plan designed by my provider, consulting with my PCP before making my own appointment with other specialists to coordinate care, requesting that any providers I see will send a report, copies of lab work, copies of test results and/or x-ray reports to my active providers, know my insurance and what it covers, be responsible for obtaining my referrals, and provide the office feedback on how they can improve.

05. NOTICE OF PRIVACY PRACTICES

I have been given a copy of Saint Clair Allergy & Asthma Center, PLLC's Notice of Privacy Practices which describes how my health information is used and shared. I understand that Saint Clair Allergy & Asthma Center, PLLC has the right to change this Notice of Privacy Practices at any time. I may obtain a current copy upon my request.

06. PATIENT/GUARDIAN ACKNOWLEDGEMENT

I have read, or have had read to me, the above policy presented by Saint Clair Allergy & Asthma Center. I acknowledge that I understand the policies above. I acknowledge that treatment received at Saint Clair Allergy & Asthma Center is a commitment and failure to comply with treatment recommendations may jeopardize my health and long-term treatment goals. I have read, understand and agree to all financial policies stated above.

Patient Name: ____ Date of Birth: ____________________

Patient/Guardian Signature: __________________________________ Date of Signature: ________________