DEMERA

540 E. Herndon Ave.
Suite 101
Fresno, CA 93720
559 431 0340
559 431 0301 fax
www.DeMeraAllergy.com

FINANCIAL POLICY

1. Payment of all insurance deductibles, co-pays, co-insurance, and non-covered services must be made at time of service.
2. We will bill all primary and secondary insurance company(s) as a courtesy to our patients. However, the complete balance must be paid within sixty (60) days from the time of service. We do not wait for insurance payments. The bill is your responsibility and not conditioned upon payment by insurance.
3. We will accept payment by cash, personal check and/or credit card.
4. All financial questions should be directed to the financial coordinator.
5. **A $75 fee will be applied to all missed appointments and/or cancellation within 24-hours of the appointment. The appointment can be rescheduled after FULL payment is received.** ____ Initials

FINANCIAL TERMS

For non-insured patients: Full payment of the fee is due prior to service. Authorized payment arrangements are available through the financial coordinator.

For patients with insurance: All deductibles, co-pays, co-insurance, and non-covered services are due at the time of service, with the entire balance of charges due within sixty (60) days from the date of service.

For patients who are members of Health Care Service Plans (HMO, PPO, and other contracted payers): Only predetermined co-payments are due at the time of service. The balance of charges must be paid within sixty (60) days from the date of service. ____ Initials

PATIENT BILLINGS

Our office bills primary and secondary insurance companies for all office visits as an accommodation for the patient.
To submit claim forms we need the following information:

PRIVATE COMPANY

1. Insurance assignment of benefits form completed and signed at the time of service.
2. Copy of insurance card(s) both sides and correct mailing address and telephone number for each insurance company. ____ Initials

CONTRACTED (HMO/PPO/IPA) INSURANCE PLANS

1. Copy of insurance card(s) both sides and correct mailing address for each insurance company.
2. Proper pre-authorization form each company as required. We will assist when possible in obtaining the authorizations; however, this is the patient's responsibility. ____ Initials

MEDICARE

1. Copy of the Medicare card at time of service.
2. The patient will be responsible for the difference between the allowable amount and the amount Medicare actually paid ____ Initials

MEDI-CAL

Unless a PDE sticker is presented at time of service, you will be directly responsible for total payment of your bill, or you may re-schedule your appointment. ____ Initials

NO INSURANCE

Arrangement for payments will be made at the time of the first office visit through the financial coordinator. ____ Initials

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1. I acknowledge and understand that I am responsible for the payment of all services rendered and will agree to pay any balance outstanding within sixty (60) days of service.
2. To the extent that payment for services rendered are made by third party payors, I hereby authorize provider to bill, collect and accept these payments on my behalf and herby assign all rights to these sums to provider.
3. I authorize you to give me reasonable and proper medical care by today's standards.
4. I hereby acknowledge that I received a copy of DeMera Allergy Asthma and Immunology Center's Notice of Privacy Practices.

Signature of Responsible Party Date