DEMERA
ALLERGY ASTHMA & ENT CENTER

Patient Name: _____ Patient Date of Birth: _____

Guardian (if patient is under 18): _____

Financial Policy

1. Payment of all insurance deductibles, co-payments, and non-covered services must be made at the time of service.
2. We will bill all insurance companies on file e.g., primary, secondary, and tertiary insurances. Once payment from insurance is received, the remaining balance must be paid by the patient or guardian within (60) days of the first generated statement.
3. We accept payments by cash, personal check, and/or credit card.
4. All financial questions should be directed to the financial coordinators. They can be reached at (559) 431-0340 ext. 218 or ext. 226.
5. **A $75.00 fee will be applied to all missed appointments and/or cancellations within 24 hours of the appointment. The appointment can be rescheduled after full payment of this fee is received.**
6. It is the responsibility of the patient to provide physical insurance cards at or before their time of service. This will ensure we bill the insurance correctly.
7. If insurance changes, it is the responsibility of the patient to update the office before the day of service.
8. If the patient has insurance that requires a referral or authorization for visits, we will assist with obtaining the proper documentation after the initial visit. However, this is ultimately the patient's responsibility follow up that all necessary referrals/authorizations are in place.
9. Any patient in a pre-collections status will not be scheduled until the pre-collections balance is paid off. A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

No Insurance / Cash Payments

1. Arrangement for payment(s) will be made at the time of service.

- 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.
- 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 hereby assign all rights to these sums to provider.
- I authorize DeMera Allergy Asthma and ENT Center treat my condition according to standard medical practice.

_____ _____
Signature of Responsible Party Today's Date

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Suite 101
Fresno, CA 93720
559 431 0340
559 431 0301 fax