Orlando Immunology Center, PA

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have health insurance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding or our payment policy.

Our physicians participate in a number of Managed Care (HMO & PPO) plans. It is your responsibility to verify that the doctor you are seeing is in "Network". Please verify this by calling the telephone number on the back of your insurance card or check with your employer as to how to obtain this information.

If you are covered by an insurance company that requires a referral from your primary care physician, please bring the referral with you at the time of your appointment or instruct your physician to call our office with the referral. We must have the referral authorization before seeing you.

Co-pays are collected at each visit according to your plan's in or out---of---network benefits. If you carry no medical coverage, payment in full is required at the time of your visit unless prior arrangements have been made. We accept cash, checks, Visa, MasterCard and Discover.

We accept Medicare assignment and will bill Medicare for you. If you have a supplemental insurance, please bring this information with you to your appointment. You may be responsible for a portion of your charges, as well as your Medicare deductible and/or coinsurance.

If you are being treated for a work---related injury (Worker's Compensation), we must have approval from your adjuster prior to your appointment. We will need the following information: Insurance carrier, address, telephone number, adjuster's name and the claim or case number.

There is a $25.00 charge for all returned checks. We do not accept post---dated checks. There will be a $25.00 fee for appointments not canceled with 24 hours.

We must emphasize that as healthcare providers, our relationship is with you, not your insurance company. While the filing of the insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial issues may affect timely payment of your account. If such issues do arise, we encourage you to contact us promptly for assistance in the management of your account.

I HAVE READ AND COMPLETETLY UNDERSTAND THE FINANCIAL POLICY OF ORLANDO IMMUNOLOGY CENTER

_____ Signature of Patient/ or Responsible Party

_____ Printed Name of Patient and/ or Responsible party

_____ Patient's Date of Birth

_____ Date