Financial Policy

Thank you for choosing Dearborn Allergy & Asthma Clinic. We are committed to providing you with quality and affordable healthcare. Below is information to answer frequently asked questions regarding patient and insurance responsibility for services rendered. Please read and initial and sign in the spaces provided. A copy will be provided to you upon request. Thank you so much for choosing our practice.

We understand that healthcare insurance can be confusing, but we are here to help you should you have questions.

Insurance: We participate with most insurance plans. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay for services rendered, it is the insurance company that makes the final determination of your eligibility.

Initials: _____

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is ultimately **your** responsibility whether or not your insurance company pays your claim. Please remember your insurance benefit is a contract between **you** and **your** insurance company.

Initials: _____

Referrals: If you have an insurance plan with which we are contracted, you need a referral authorization from your primary care physician/pediatrician. If we have not received a referral prior to your arrival at the office, you may call your primary care physician to obtain a referral. If you are unable to obtain the referral at that time, you will be rescheduled.

Initials: _____

Co-payments and Deductibles: All co-pays, deductibles, and co-insurance MUST BE paid at the time of service. This arrangement is part of your contract with **YOUR** insurance company.

Initials: _____

Proof of Insurance: All patients must complete our patient information form before seeing our providers. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of your claim.

Initials: _____

Divorce Cases: When a minor child is brought in, the parent that brings that child in is responsible for payment regardless of divorce decree.

Initials: _____

Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Initials: _____

Methods of Payment: We have many different options available for you to pay your account balance. Please see attached for additional information.

Initials: _____

Patient Statements: If you have an unpaid balance, you will receive a statement by mail at 30 and 60 days. The statement amount is due and payable when the statement is issued, and past due if not paid upon receipt. Balances over 60 days will be turned over to an attorney or collection agency for collections. All payments made will go to the oldest outstanding balance.

Initials: _____

No Show Fee: Please notify us 1 business day (24 hours) prior to your appointment if you must cancel or reschedule. Failure to notify us will result in a **$50.00** no show/cancel fee for new patients and **$25.00** for established patients. The no show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

Initials: _____

Collection Fees: Balances that have not had a payment or payment plan in place will be turned over to collections. Additional fees such as interest and collection agency fees may be applied.

Initials: _____

Ultimately, you are responsible for any balance that your insurance states is your co-pay and deductible. It is your responsibility to verify with your insurance company what your out-of-pocket costs are. If you need any codes in the process of verifying, please make sure to call the office at (313) 565-3565, and we will be happy to provide these to you.

Patient's Name: _____ **Date: _____**

Responsible Party: _____

Signature: _____