



## ALLERGY & ASTHMA CLINICS OF GEORGIA, P.C.

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*Adult & Pediatric Allergy*

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Re: New Patient Appointment

We are excited that you have chosen our clinic as your allergy and asthma provider. We promise to provide you with the best possible healthcare available and to make your experience with our office as pleasant as possible.

As an allergy and asthma specialty clinic, we work closely with your primary care doctor (family practice, internal medicine, pediatrician, etc.) to treat your symptoms directly related to allergies and asthma. As we monitor your progress of our treatment plan, we ask that you maintain your relationship and communication with your primary care doctor for treatment of all illnesses not related to allergies and asthma.

In order to speed up the registration process, please fill out the enclosed forms and bring them with you to your appointment. You will also need to bring your insurance card. *Please Note: If you are on Medicaid, you will need to bring your card in order to be seen.* We ask that you not take any antihistamines three days prior to your visit in case you are a candidate for skin testing.

Again, we appreciate the opportunity to serve you. If you have any questions or comments, please do not hesitate to give us a call.

Sincerely,

ALLERGY & ASTHMA CLINICS OF GEORGIA, P.C.

*T. Alan Moree*

T. Alan Moree  
Practice Administrator

105 Spanish Court ▪ Albany, Georgia 31707 ▪ (229) 438-7100  
1038-B East Forsyth Street ▪ Americus, Georgia 31709 ▪ (229) 924-3177  
200 Doctors Drive, Suite 102 ▪ Douglas, Georgia 31533 ▪ (912) 260-1222

# ALLERGY & ASTHMA CLINICS OF GEORGIA, P.C.

## Financial Agreement

This agreement made and entered into to be effective as of the date recorded below between Allergy & Asthma Clinics of Georgia, P.C. (herein referred to as AACG) and Patient, or Responsible Party if not the Patient, (herein referred to as Patient) named below.

By executing this agreement, Patient agrees to pay for all services provided by AACG.

**Monthly Statement:** If Patient has a balance on his/her account, he/she will receive a monthly statement. The statement will show any previous balance due, any new charges to Patient's account, and any payments or credits applied during the month.

**Payments:** Unless other arrangements are approved by AACG in writing, the Patient's balance is due when the statement is issued and is considered past due if not paid within 30 days of the statement date.

**Charges to Account:** AACG shall have the right at any time to cancel Patient's privilege to make charges against his/her account. If AACG exercises this right, Patient would be required to pay in full at the time of service.

**Required Payments:** Any co-payments required by an insurance company must be paid at the time of service. If Patient does not have insurance coverage, he/she will be expected to pay at least 50% of the visit charge at the time of service.

**Payment Options:** Patient will have the following three options:

1. Pay co-payment or deductible and any out-of-pocket portions at the time services by cash, check, or credit card. AACG will file with Patient's insurance carrier.
2. Pay for entire visit by cash, check, or credit card. AACG will file with Patient's insurance carrier and request that the insurance carrier send their payment directly to Patient.
3. Pay for entire visit by cash, check, or credit card. Patient will file with their insurance carrier.

**Insurance:** Insurance coverage is a contract between Patient and the insurance carrier. AACG is NOT a party to this contract in most cases. AACG will bill Patient's primary insurance carrier as a courtesy. If a second attempt at filing becomes necessary and is unsuccessful, Patient will become responsible for payment in full. Although AACG may estimate what Patient's insurance carrier may pay, it is the insurance carrier that makes the final determination of eligibility. If Patient's insurance carrier requires a referral and/or pre-authorization, it is the Patient's responsibility to obtain that referral and/or pre-authorization. Failure to obtain a referral and/or pre-authorization may result in a lower payment from the insurance carrier.

**Divorce:** In case of divorce or separation, the party responsible for the account prior to the divorce or separation will remain responsible for the balance due. After a divorce or separation, the parent that authorizes treatment for the child will be the parent responsible for subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it will be the authorizing parent's responsibility to collect from the other parent.

**Past Due Accounts:** AACG will take all of the necessary steps allowed by law to collect on past due accounts. If Patient's account becomes past due, it is the responsibility of Patient to contact AACG to set up a payment plan. Patients on a payment plan shall pay 25% of the balance when the payment plan is initiated and shall pay 10% of the balance monthly. Any charges incurred in addition to the amount on the payment plan must be paid in full at the time of visit. This amount may not be added to the old balance. If AACG is forced to refer the Patient's account to an outside collection agency, a service charge, which will be 10% of the account balance, will be added to the Patient's account.

**Credit History:** AACG has the option to report Patient's account status to any credit-reporting agency, such as a credit bureau or collection agency.

**Returned Checks:** AACG will charge a fee in the amount of \$25 for each check returned by the Patient's bank.

**Transferring of Records:** When appropriate, Patient will sign an Authorization Form for Protected Health Information to be released from our practice to another organization.

**Workers Compensation:** AACG requires a written approval/authorization by Patient's employer and/or workers compensation carrier prior to Patient's initial visit. If claim is denied, Patient will be responsible any and all charges.

By signing this agreement, Patient agrees to all of the terms and conditions contained herein and the agreement will be in full force and effect. If Patient refuses to sign this agreement, Patient will be considered a self-pay patient and will be expected to pay balance due at the time of service.

Patient's Name: \_\_\_\_\_

Responsible Party  
(if not the patient): \_\_\_\_\_

Signature  
(Responsible Party): \_\_\_\_\_ Date: \_\_\_\_\_

## ALLERGY & ASTHMA CLINICS OF GEORGIA, P.C.

Category: Appointments

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Title: Missed Appointments

Policy #: 3030

Origination Date: 07/01/01

Review Date: 02/26/03

Revision Date: 02/26/03

Authorization: \_\_\_\_\_

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### Policy

Patients who consistently fail to present themselves for scheduled appointments or fail to cancel their appointments 24 hours prior to scheduled appointments will be considered chronic no-show patients. The Clinic Manager will review each case individually.

### Procedures

1. Patients will be notified of the no-show policy at the time of initial registration.
2. When new patients who are referred miss their appointments, a letter is sent to the referring physician to let them know of the missed appointment.
3. A patient's file will be noted with "DNKA" (Did Not Keep Appointment) when the patient fails to show or give sufficient notice of cancellation for a scheduled appointment.
4. A patient is labeled as a chronic no-show patient when he/she fails to show (or give sufficient notice of cancellation) for two (2) scheduled appointments within a twelve (12) month period. For chronic no-show patients, the Clinic Manager will send a letter by certified mail explaining the chronic no-show policy and requesting the patient adhere to the policy.
5. Patients who fail to show (or give sufficient notice of cancellation) for a scheduled appointment within six (6) months of receiving the letter from the Clinic Manager will be sent another certified letter discharging them as a patient.