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FINANCIAL POLICIES/INSURANCE AUTHORIZATION

Patient Name:_____ SS#_____

Dear Patient,

Thank you for choosing us as your health care provider. This document is a summary of our financial policies, and explanation of your responsibilities, and authorization to bill your insurance on your behalf for services provided to you.

You may be responsible for co-payments, deductibles and services provided which may not be considered a benefit under your policy. Your insurance may deny claims for a variety of reasons:

1. The services provided may not be a benefit of your health insurance policy or may not be covered when provided by our office (mental health services, laboratory, etc.).
2. You may have exhausted your benefit for the services provided.
3. MEDICAL NECESSITY or MEDICALLY NECESSARY generally means a determination based upon criteria and guidelines developed by your insurance carrier in consideration of generally accepted standards and practices. The services must meet all of the following criteria:
    a. It is generally accepted as necessary and appropriate for the patient's condition , given the symptoms, and is consistent with the diagnosis; and
    b. It is essential or relevant to the evaluation or treatment of the disease, injury, condition, or illness and is not mainly for the convenience of the member or Physician; and
    c. It is reasonably expected to improve the patient's condition or level of functioning or, in the case of diagnostic testing, results are used in the diagnosis and/or management of the patient's care.

To Our CMS(Medicare) Patients Only

CMS will only pay for services that it determines to be "reasonable and necessary" under Section 1862 (a)(1) of the CMS Law. However if CMS determines that a particular service is not "reasonable and necessary" under their guidelines, payment may be denied. CMS's guidelines for medical necessity are similar to those listed above. We may request you sign a separate form if we anticipate CMS will not pay for services provided.

Lifetime Beneficiary Claim Authorization

I request that payment of authorized CMS benefits be made on my behalf to Kenwood Allergy And Asthma Center, P.C. for any services furnished to me. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits payable to related services in accordance with Health Insurance Portability and Accountability Act (HIPAA).

I understand my signature requests that payment be made to my physician and authorizes the release of medical information necessary to pay the claim. If other health insurance coverage is indicated on approved claim forms or electronically submitted claims, my signature authorizes the releasing of the information to the insurer or agency shown. My physician agrees to accept the charge determination of the CMS carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based on the charge determination of the CMS carrier.

Patient/Responsible Party Statement

If my physician does not participate with my insurance company or my insurance company does not pay for the service provided, I agree to be personally and fully responsible for payment. I also accept responsibility for any co-payments and/or deductibles. I understand a statement of my charges and payments will be sent to my mailing address unless I otherwise indicate. I understand there is a $25 fee for returned personal checks. I understand there may be missed appointment charges if I fail to notify you within 24 hours of my appointment. I have signed this form prior to any services rendered.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Witness Date