certified
ALLERGY & ASTHMA
consultants

THE MORE YOU KNOW, **THE BETTER YOU'LL FEEL.**

Thank you for choosing our Practice as a part of your medical care team. The documents which follow comprise our New Patient Forms Package some of which we ask that you complete and bring to your visit. This will allow us to expedite the check-in process.

Accompanying Documents:

FORM A	Patient Information Sheet (Please complete)
FORM B	Patient Portal Enrollment (Please complete if interested in the patient portal)
FORM C	Privacy Acknowledgment and Consent (Please complete)
FORM D	Notice of Privacy Practices
FORM E	Our Financial Policies

We look forward to welcoming you to our Practice.

FORM A – PLEASE COMPLETE AND BRING TO YOUR VISIT

Patient Information Sheet

1. Additional Demographic information:

This additional demographic information is requested to comply with Federal Health Care Reform legislation.

a. Preferred Language: English____ Other (specify) _____

b. Race: ( ) American Indian *or* Alaskan Native ( ) Asian ( ) Black *or* African American

( ) Native Hawaiian or Other Pacific Islander ( ) White

c. Ethnicity: ( ) Hispanic *or* Latino ( ) Not Hispanic *or* Latino

Preferred local pharmacy: _____ _____ _____
Name Street City

Do you use a mail order pharmacy? ( ) Yes: ( ) CVS/Caremark ( ) Express Scripts ( ) Optum RX ( ) Walgreens ( ) Other _____
( ) No

Other than your Primary Care Physician, is there another Physician who should receive copies of reports?

( )Yes Physician's Name**:**_____
( )No

2. Review of Systems: Are you <u>currently</u> experiencing any of the following symptoms?

General: ( ) Weight change ( ) Sleeping difficulty ( ) Nervousness ( ) Depression
( ) No symptoms

Skin: ( ) Rash **( ) No symptoms**

HEENT: ( ) Decreased hearing ( ) Ear infections ( ) Runny nose ( ) Nasal congestion ( ) Mouth breathing ( ) Nose bleed ( ) Sneezing ( ) Sore throat ( ) Watery eyes ( ) Itchy eyes ( ) Facial injury ( ) Sinus infection ( ) Post nasal drip ( ) Hoarseness **( ) No symptoms**

Respiratory: ( ) Cough ( ) Wheezing ( ) Shortness of breath **( ) No symptoms**

Cardiovascular: ( ) Chest pain ( ) Palpitations **( ) No symptoms**

Gastrointestinal: ( ) Abdominal pain ( ) Change in bowel habits ( ) Difficulty swallowing ( ) Heartburn ( ) Indigestion ( ) Nausea ( ) Vomiting ( ) Liver problems **( ) No symptoms**

Musculoskeletal: ( ) Joint pain ( ) Muscle weakness ( ) Swelling **( ) No symptoms**

Neurological: ( ) Dizziness ( ) Fainting ( ) Headaches **( ) No symptoms**

Endocrine: ( ) Thyroid problems ( ) Diabetes ( ) Chronic fatigue **( ) No symptoms**

3. What is your smoking history (All patients age 13+) ? ( ) Never smoked ( ) Current every day smoker
( ) Current some day smoker ____ ( ) Cigarettes How many packs per day? **____** ( ) Pipe ( ) Cigar

( ) Former smoker In what year did you quit? _____ How many years did you smoke? _____
How many packs per day? _____

4. Current school setting: ( ) Daycare center ( ) Pre-school ( ) School Grade _____ ( ) Home Schooled ( ) College

5. Current Occupation: _____

6. S**moke exposure in any home:** ( ) Yes ( ) No

7. Number of Animals in any home: ( ) No animals present

Cat(s): _____

Dog(s): _____

Other: _____

FORM B – PLEASE COMPLETE AND BRING TO YOUR VISIT

(To obtain a patient portal account)

Certified Allergy & Asthma Consultants

FollowMyHealth Patient Portal Access Request

Please complete this form to request online access to **your** health information through our FollowMyHealth Patient Portal. Once you are enrolled, you will receive an e-mail invitation from **noreply@FollowMyHealth.com** with instructions on creating your portal account.

Patient Information (Age 18+)

First Name	Last Name	Date of Birth

Address	City	State	ZIP

Email address (to receive the invitation)	Phone #

I also authorize the following person/persons to receive an e-mail invitation for access to my patient portal account as a Proxy and understand that medical information contained in my record will be available to them on a continuing basis unless and until I revoke their access by contacting you in writing to request proxy access be removed.

Additional Proxy Access, if applicable (If you do not want to designate a Proxy, leave blank.)

First Name	Last Name	Relationship to me	Invitation email address

I hereby request enrollment in Certified Allergy & Asthma Consultants' patient portal and creation of proxy access as indicated above, if applicable.

Signature	Date

For office use only

MRN: _____ _____ _____ _____

Verified by: _____ Date: _____

Processed by: _____ Date: _____

Certified Allergy & Asthma Consultants
FollowMyHealth Patient Portal Access Request

Please complete this form to request online access to the health information of a **minor family member** through our FollowMyHealth Patient Portal. Once you are enrolled, you will receive an e-mail invitation from **noreply@FollowMyHealth.com** with instructions on creating a portal account and/or accessing health information for your family member(s).

Patient Information (Minor < 18 years old)

Provide information for each minor for whom you are requesting a portal account.

(1) First Name	Last Name	Date of Birth	
Address	City	State	ZIP

(2) First Name	Last Name	Date of Birth	
Address	City	State	ZIP

(3) First Name	Last Name	Date of Birth	
Address	City	State	ZIP

Information About You

First Name	Last Name	Relationship to Minor(s)	
Address	City	State	ZIP

Email address (to receive the invitation)	Phone #

I hereby request enrollment in Certified Allergy & Asthma Consultants' patient portal as a Proxy for the minor(s) indicated above. I understand that upon the minor(s) attaining age 18, my access to their medical information through the patient portal will terminate automatically.

Signature	Date

FORM C – PLEASE COMPLETE AND BRING TO YOUR VISIT

Patient Name _____ Date of Birth _____

CERTIFIED ALLERGY & ASTHMA CONSULTANTS
Notice Regarding Privacy of Personal Health Information

Please sign below to acknowledge the receipt of our Privacy Policy.

ACKNOWLEDGEMENT

I, _____, acknowledge that I have received a copy of
(Patient Name or Parent if Patient is a Minor)

CERTIFIED ALLERGY & ASTHMA CONSULTANTS' Notice Regarding Privacy of Personal Health Information.

X _____ _____
(Patient **Signature** or Parent if Patient is a Minor) Date

CONSENT TO RELEASE INFORMATION

New York Law requires that we obtain your consent to release your (your child's) medical information to others including referring physicians and your insurance company.

Please sign below to authorize the release of your medical information.

I, _____, consent to the release of personal health
(Patient Name or Parent if Patient is a Minor)

information (other than information relating to mental health, alcohol or substance abuse, genetic counseling or HIV/AIDS-related information) for the purposes of treatment, payment and health care operations until such time as my consent is restricted or revoked by me in writing.

X _____ _____
(Patient **Signature** or Parent if Patient is a Minor) Date

FORM D – RETAIN FOR YOUR RECORDS

NOTICE REGARDING PRIVACY OF PERSONAL HEALTH INFORMATION
FOR
CERTIFIED ALLERGY & ASTHMA CONSULTANTS
(referred to as "the practice" throughout this Notice)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Federal regulations developed under the Health Insurance Portability and Accountability Act (HIPAA) require that the practice provide you with this Notice Regarding Privacy of Personal Health Information. The Notice describes (1) how the practice may use and disclose your protected health information, (2) your rights to access and control your protected health information in certain circumstances, and (3) the practices' duties and contact information.

I. Protected Health Information
"Protected health information" is health information created or received by your health care provider that contains information that may be used to identify you, such as demographic data. It includes written or oral health information that relates to your past, present or future physical or mental health; the provision of health care to you; and your past, present, or future payment for health care.

II. The Use and Disclosure of Protected Health Information in Treatment, Payment, and Health Care Operations
Your protected health information may be used and disclosed by the practice in the course of providing treatment, obtaining payment for treatment, and conducting health care operations. Any disclosures may be made in writing, electronically, by facsimile, or orally. We will request your consent for the continuous release of such information. You may revoke this consent at any time by advising our Privacy Officer, as identified at the bottom of this notice, in writing.

The practice may also use or disclose your protected health information in other circumstances if you authorize the use or disclosure, or if state law or the HIPAA privacy regulations authorize the use or disclosure.

***Treatment*.** The practice may use and disclose your protected health information in the course of providing or managing your health care as well as any related services. For the purpose of treatment, the practice may coordinate your health care with a third party. For example, the practice may disclose your protected health information to a pharmacy to fulfill a prescription for asthma medication, to an X-ray facility to order an X-ray, or to another physician who is administering your allergy shots which we prepared. In addition, the practice may disclose protected health information to other physicians or health care providers for treatment activities of those other providers.

***Payment*.** When needed, the practice will use or disclose your protected health information to obtain payment for its services. Such uses or disclosures may include disclosures to your health insurer to get approval for a recommended treatment or to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. When obtaining payment for your health care, the practice may also disclose your protected health information to your insurance company to demonstrate the medical necessity of the care or for utilization review when required to do so by your insurance company. Finally, the practice may also disclose your protected health information to another provider where that provider is involved in your care and requires the information to obtain payment.

Health Care Operations. The practice may use or disclose your protected health information when needed for the practice's health care operations for the purposes of management or administration of the practice and of offering quality health care services. Health care operations may include:
(1) quality evaluations and improvement activities; (2) employee review activities and training programs; (3) accreditation, certification, licensing, or credentialing activities; (4) reviews and audits such as compliance reviews, medical reviews, legal services, and maintaining compliance programs; and (5) business management and general administrative activities. For instance, the practice may use, as needed, protected health information of patients to review their treatment course when making quality assessments regarding allergy care or treatment. In addition, the practice may disclose your protected health information to another provider or health plan for their health care operations.

Other Uses and Disclosures. As part of treatment, payment, and health care operations, the practice may also use or disclose your protected health information:
(1) to remind you of an appointment including sending you an appointment reminder by mail or e-mail and/or leaving appointment reminder information on your telephone answering machine or voice mail;
(2) to inform you of potential treatment alternatives or options;

(3) to inform you of health-related benefits or services that may be of interest to you;
(4) for research purposes. We may use and disclose your protected health information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your protected health information. Even without that special approval, we may permit researchers to look at protected health information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any protected health information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

III. Additional Uses and Disclosures Permitted Without Authorization or an Opportunity to Object
In addition to treatment, payment, and health care operations, the practice may use or disclose your protected health information without your permission or authorization in certain circumstances, including:

***When Legally Required*.** The practice will comply with any Federal, state or local law that requires it to disclose your protected health information.

***When Necessary to Protect Public Health*.** The practice may disclose your protected health information for public health purposes, including to, as permitted or required by law:
(1) Prevent, control, or report disease, injury, or disability;
(2) Report vital events such as birth or death;
(3) Conduct public health surveillance, investigations, and interventions;
(4) Collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs, or replacements, and conduct post marketing surveillance;
(5) Notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease (but only in accordance with state law); and
(6) Report to an employer information about an individual who is a member of the workforce when information is related to a medical surveillance of the workplace or to evaluate whether an illness or injury is work-related. A separate notice will be provided to you in these circumstances.

***To Report Abuse, Neglect or Domestic Violence*.** As required or authorized by law or with the patient's agreement, the practice may inform government authorities if it is believed that a patient is the victim of abuse, neglect or domestic violence.

***To Conduct Health Oversight Activities*.** The practice may disclose your protected health information to a health oversight agency for use in (1) audits; (2) civil, administrative, or criminal investigations, proceedings or actions; (3) inspections; (4) licensure or disciplinary actions; or (5) other necessary oversight activities as permitted by law. However, if you are the subject of an investigation, the practice will not disclose protected health information that is not directly related to your receipt of health care or public benefits.

For Judicial and Administrative Proceedings. The practice may disclose your protected health information for any judicial or administrative proceeding if the disclosure is expressly authorized by an order of a court or administrative tribunal as expressly authorized by such order or a signed authorization is provided.

***For Law Enforcement Purposes*.** The practice may disclose your protected health information to a law enforcement official for law enforcement purposes when:
(1) Required by law to report of certain types of physical injuries;
(2) Required by court order, court-ordered warrant, subpoena, summons or similar process;
(3) Needed to identify or locate a suspect, fugitive, material witness or missing person;
(4) Needed to report a crime in an emergency situation;
(5) You are the victim of a crime in specific limited instances;
(6) Your death is suspected by the practice to be the result of criminal conduct; or
(7) The practice believes your protected health information is evidence of a crime committed on the premises of the practice.

***To Coroners, Funeral Directors, and for Organ Donation*.** The practice may disclose protected health information to a coroner or medical examiner for the purpose of (1) identification, (2) determination of cause of death, or (3) performance of the coroner or medical examiner's other duties as authorized by law. In addition, as permitted by law, the practice may disclose protected health information, including when death is reasonably anticipated, to a funeral director to enable the funeral director to carry out his or her duties. Protected health information may also be used and disclosed for the purpose of cadaveric organ, eye or tissue donation.

***To Prevent or Diminish a Serious and Imminent Threat to Health or Safety*.** If in good faith the practice believes that use or disclosure of your protected health information is necessary to prevent or diminish a serious and imminent threat to the health and safety of a person or of the public, the practice may use or disclose your protected health information as permitted under law and consistent with ethical standards of conduct.

***For Specified Government Functions*.** As authorized by the HIPAA privacy regulations or state law, the practice may use or disclose your protected health information to facilitate specified government functions relating to military and

veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

For Worker's Compensation. The practice may disclose your protected health information to comply with worker's compensation laws or similar programs.

For Use by Business Associates. We may disclose protected health information to our business associates who perform functions on our behalf or provide us with services if the protected health information is necessary for those functions or services. For example, we use another company to provide electronic health record software to us which contains your protected health information. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your protected health information.

***For Data Breach Notification Purposes*.** We may use or disclose your protected health information to provide legally required notices of unauthorized access to or disclosure of your health information.

IV. Uses and Disclosures Permitted With An Opportunity to Object

Subject to your objection, the practice may disclose your protected health information (1) to a family member or close personal friend if the disclosure is directly relevant to the person's involvement in your care or payment related to your care; or (2) when attempting to locate or notify family members or others involved in your care to inform them of your location, condition or death. The practice will inform you orally or in writing of such uses and disclosures of your protected health information as well as provide you with an opportunity to object in advance. Your agreement or objection to the uses and disclosures can be oral or in writing. The practice may disclose your health information to a friend or family member as described at (1) and (2) if: (a) you are present and do not object to these disclosures; (b) the practice is able to infer from the circumstances that you do not object; or (c) the practice determines, in its professional judgment, that it is in your best interests for the practice to disclose information that is directly relevant to the person's involvement with your care. If you are incapacitated or in an emergency situation, the practice may exercise its professional judgment to determine if the disclosure is in your best interests and, if such a determination is made, may only disclose information directly relevant to your health care.

We may also use or disclose your protected health information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

V. Uses and Disclosures Authorized by You

Other than the circumstances described above, the practice will not disclose your health information unless you provide written authorization. Your written authorization is also required for the use and disclosure of your protected health information for marketing purposes and for disclosures that constitute a sale of such information. Your authorization is also required for use and disclosure of psychotherapy notes. You may revoke your authorization in writing at any time except to the extent that the practice has taken action in reliance upon the authorization.

VI. Your Rights

You have certain rights regarding your protected health information under the HIPAA privacy regulations. These rights include:

The right to request a restriction on uses and disclosures of your protected health information. You may request that the practice not use or disclose specific sections of your protected health information for the purposes of treatment, payment, or health care operations. Additionally, you may request that the practice not disclose your health information to family members or friends who may be involved in your care or for purposes of notifying friends and family of your location, condition, or death. In your request, you must specify the scope of restriction requested as well as the individuals for which you want the restriction to apply. Your request should be directed to the practice's Privacy Officer. The practice may choose to deny your request for a restriction unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. "Out-of-pocket" payments are those payments for health care services you have made in full for which you have requested we not bill your insurance company. If your request for a different restriction is denied, the practice will notify you of its decision. Once the practice agrees to a requested restriction, the practice may not violate that restriction unless use or disclosure of the relevant information is needed to provide emergency treatment. The practice may terminate the agreement to a restriction in some instances.

The right to request to receive confidential communications from the practice by alternative means or at an alternative location. You have the right to request that the practice communicates with you through alternative means or at an alternative location. The practice will make every effort to comply with reasonable requests. However, the practice may condition its compliance by asking you for information regarding the procurement of payment or specific information regarding an alternative address or other method of contact. You are not required to provide an explanation for your request. Requests should be made in writing to the practice's Privacy Officer.

***The right to inspect and copy your protected health information*.** You have the right to inspect and copy your protected health information for as long as we maintain it, subject to certain limitations. If we deny your request to inspect and copy your protected health information we will provide you with a written notice of the reason for the denial including

an explanation of any appeal rights you may have. We may impose a fee for copies as permitted by state or Federal law. Requests for review and copying of your protected health information should be directed to the Privacy Officer.

The right to an electronic copy of electronic medical records. If your protected health information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your protected health information in the form or format you request, if it is readily producible in such form or format. If the protected health information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

***The right to request an amendment of your protected health information*.**
During the time that the practice holds your protected health information, you may request an amendment of your information in a designated record set. The practice may deny your request in some instances. However, should the practice deny your request for amendment, you have the right to file a statement of disagreement with the practice. In turn, the practice may develop a rebuttal to your statement. If it does so, the practice will provide you with a copy of the rebuttal. Requests for amendment must be submitted in writing to the practice's Privacy Officer. Your written request must supply a reason to support the requested amendments.

***The right to request an accounting of certain disclosures*.** You have the right to request an accounting of the practice's disclosures of your protected health information made for purposes **other than** treatment, payment or health care operations as described in this Notice. The practice is not required to account for disclosures (1) which you requested, (2) which you authorized by signing an authorization form, (3) for a facility directory, (4) to friends or family members involved in your care, and (5) certain other disclosures the practice is permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer and should state the time period for which you wish the accounting to include up to a six year period. The practice is not required to provide an accounting for disclosures that take place **prior to April 14, 2003**. The practice will not charge you for the first accounting you request of any 12-month period. Subsequent accountings may require a fee based on the practice's reasonable costs for compliance with the request.

The right to receive a notice of breach. You have the right to be notified upon a breach of any of your unsecured protected health information.

***The right to obtain a paper copy of this Notice*.** The practice will provide a separate paper copy of this Notice upon request even if you have already been given a copy of it or have agreed to review it electronically.

VII. The Practice's Duties

The practice is required to ensure the privacy of your health information and to provide you with this Notice of your rights and the practice's duties and procedures regarding your privacy. The practice must abide by the terms of this Notice, as may be amended periodically. The practice reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that the practice collects and maintains. The current Notice is available in our office and on our website.

VIII. Complaints

If you believe that your privacy rights have been violated, you have the right to relate complaints to the practice and to the Secretary of the Department of Health and Human Services. You may provide complaints to the practice verbally or in writing. Such complaints should be directed to the practice's Privacy Officer. The practice encourages you to relate any concerns you may have regarding the privacy of your information and you will not be retaliated against in any way for filing a complaint.

IX. Contact Person/Exercising Your Rights

The practice's contact person regarding the practice's duties and your rights under the HIPAA privacy regulations is the Privacy Officer. To exercise your rights described in the Notice, send your request, in writing, to the Privacy Officer. The Privacy Officer can provide information regarding issues related to this Notice by request. Complaints or requests should be directed to the Privacy Officer at the following address:

CERTIFIED ALLERGY & ASTHMA CONSULTANTS
8 Southwoods Blvd.
Albany, NY 12211
ATTN: Thomas J. Derrico, Privacy Officer

The Privacy Officer can be contacted by telephone at (518) 434-1446.

X. Effective Date

This Notice is effective on September 23, 2013.

FORM E - RETAIN FOR YOUR REFERENCE

Our Financial Policies

Concerns or Questions? Call our Business Office at (518) 434-1456, x3280.

Welcome to Certified Allergy & Asthma Consultants
Thank you for choosing Certified Allergy & Asthma Consultants (Certified Allergy) as your provider of allergy and asthma care. We are pleased to have you as a patient. Certified Allergy is dedicated to providing quality, accessible and cost effective health care and we strive to make every visit a positive experience. This document is designed to provide our patients with an explanation of our financial policies. Should this information not address your specific situation or if you have questions or concerns about your account, we encourage you to speak with a member of our Business Office staff.

Within this policy, the word "patient" can mean the patient of the practice or, in the case of minor children, the patient's parent or guardian.

Participation with Insurance Companies
We have contractual agreements with many insurance companies and also participate with Medicare and New York Medicaid. We will bill these organizations in accordance with the terms of our contracts. Certified Allergy reserves the right to determine which insurance companies or programs we participate with on an annual basis.

Our Services and Insurance Plan Coverage
Insurance coverage for allergy and asthma testing and treatment varies by insurance company, and can vary by each individual insurance plan offered by insurance companies or employers. If you have questions regarding the extent to which your insurance company will cover our services, please contact your insurance company or our Business Office prior to your visit. Common services provided by Certified Allergy can include an office visit, skin testing, pulmonary function testing, ingestion challenges and allergy immunotherapy.

Patients Without Insurance
For our uninsured patients, payment in full is due at the time of service, unless other payment arrangements have been made in advance with our Business Office.

General Insurance Policy
We will file claims with your insurance carrier provided we have your current insurance policy information available. We cannot guarantee that your insurance carrier will pay all or even part of your claim. Your insurance policy is a contract between you and your insurance carrier. Ultimately you, as the patient, are responsible for payment to Certified Allergy. You should resolve disputed coverage issues directly with your insurer or employer. It is your responsibility to know the details of your insurance contract and whether our physicians are network providers for your particular plan.

When your insurance company processes your claim they may provide you with an Explanation of Benefits (EOB). This EOB will explain the amount the insurance company has agreed to pay. Most insurance companies agree to pay only a portion of the charges with the remaining balance being the responsibility of the patient. Because of policy deductibles, co-insurance, co-payments and possibly non-covered services, you may have a balance due after your insurance company processes your claims.

Co-payments
Co-payments and deposits will be collected at the time of your visit. Please check with your insurance company regarding any specialist co-pay requirements.

Deductibles and Co-Insurance
Many insurance plans now include annual deductibles requiring patients and their families to pay for medical services up to a specified dollar amount before the insurance company will pay for any medical services.
Once the annual deductible has been met, patients may still be responsible for fixed co-payments or a percentage of costs (co-insurance). Deductible and co-insurance balances for our services will be determined by your insurance company when they process your claims. If you are not enrolled in our Credit Card on File program, we will send you a statement when the claims have been processed. **Patients with unmet deductibles may be asked to pay a deposit at the time of their visit depending on the nature of the visit.**

Forms of Payment Accepted
We accept cash, check, debit cards and all major credit cards. In addition, you can pay balances due on your account securely via credit card using the Online Bill Pay link on our website (certifiedallergy.com).

Credit Card on File Program
We encourage all patients to enroll in our "Credit Card on File" program and authorize Certified Allergy to charge your credit or debit card each month for amounts due from you after your insurance plan processes our claims. You may place limits on the amount that can be charged without further authorization from you. We will send you a statement detailing all amounts paid under the program.

Statements and Payment Expectations
Certified Allergy generates and mails account statements every **4** weeks. All outstanding account balances are due within 21 days of the first statement. **For all subsequent statements, a $5 statement fee will be added to the amount that you owe.** We maintain separate accounts for each patient, and generate statements for each patient's account.

General Credit Policies and Payment Plans
If you know that you will not be able to pay your bill, please contact our Business Office at (518) 434-1456 (ext. 3280) to discuss payment options which may be available to you.

Balance Collection Efforts and Discharge for Non-Payment
If you have an outstanding past due balance, we may send your account to an outside collection agency to assist us in contacting you and obtaining payment. All of our efforts to obtain payment, whether performed internally or by an outside third party, will comply with all applicable regulations. If your account is turned over to our outside collection agency due to non-payment, you will be discharged from our care and receive notice of such discharge. Following discharge, you will not be able to receive care from our office.

Financial Responsibility
For patients 19 or older, the responsible party is presumed to be the patient. If another party is responsible for a patient's medical costs, please provide us with that person's name and contact information. In the case of minor children, we will presume that either of the child's parents is financially responsible for the costs of their medical care unless we are provided with information that specifically designates one parent as the responsible party (see next paragraph).

Families Divided by Separation or Divorce
We understand that families divided by separation or divorce may have specific billing requirements. All efforts will be made to comply with these requirements if they are known to us in advance. We will attempt to collect any account balances from the parent designated as the responsible party. That person will receive account statements and other correspondence regarding the child's account status.

Referrals
If your insurance plan requires a referral from your Primary Care Provider (PCP) for specialist services to be provided by our Practice, it is your responsibility to obtain the referral for the appropriate dates of service. Failure to obtain a valid referral for our services in advance may result in denial of coverage by your insurance company. The balance of charges due on those services will become your responsibility at the time of denial by the insurance company.

Bounced Checks
If your bank returns your check payment to us due to insufficient funds in your account, we will charge you a bounced check fee of $25.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.