## WELCOME TO ST. PAUL ALLERGY & ASTHMA CLINIC, P.A

## CREDIT POLICY

PATIENT NAME: ______________________

All charges incurred in our office are your responsibility. You will receive a statement from our office. All charges are payable within thirty days of the statement date. Any amount sixty days or older will be subject to a monthly service charge of 1 1/3% per month. Annual percent is sixteen (16%).

For your convenience we accept cash, checks, Visa and Mastercard. Our return check fee is $20.00.

If you have insurance coverage you will need to present a CURRENT insurance card at the time of service. Failure to do so will release St. Paul Allergy & Asthma Clinic, P.A. from any responsibility for incorrect or untimely filing of contracted claims. In the event of any insurance change due to a different group, policy, or insurance company, please notify our office immediately to ensure proper billing. A copy of your new card will be required.

We are specialists for many HMO and PPO organizations. Please check your insurance provider manual to determine if St. Paul Allergy & Asthma Clinic, P.A. is participating with your plan. If you are a member of a HMO it is necessary to be referred by your primary care physician before you schedule your appointment. You will be responsible for obtaining a referral. Services rendered without a referral will be billed to the patient.

If your insurance requires that you make a co-payment, it is due at the time of service. Please be prepared to pay this at each visit.

We employ a full business office staff to assist you with any questions you may have regarding billing and insurance. They are available by phone form 8:30- 5:00 Monday through Friday at 651-698-9108.

I have read and understand the above statement. Signed: ______________________
Relationship to patient if not self: ______________________
Date: ______________