



STATEMENT OF FINANCIAL RESPONSIBILITY

As a courtesy to you, our office will submit claim(s) to your Health Insurance Carrier(s) for the services provided to you or your covered family members.

You will be responsible for any and all Co-Payments, Deductibles and for charges not covered by your health insurance carrier(s). All payments are due during the time of service based on available information.

If no payment is received from your insurance carrier(s) within 90 (ninety) days from the date of service, the bill becomes your responsibility. Our office will bill you for the amount owed. In the event your insurance carrier(s) denies payment to the claim(s) or pays only partial payment, the bill becomes your responsibility.

In the event your insurance carrier(s) send payment to you directly, you agree to pay that amount immediately to our office.

Should the account be referred to the collections agency, the undersigned shall be responsible for an additional \$50.00 collection cost plus attorney fees.

OUR OFFICE POLICY CONCERNING APPOINTMENTS

Drs. Chamorthy and Sanka limit the number of appointments they makes on a daily basis, so that they can spend adequate time with each patient to provide the highest quality of medical care. Short notice cancellations, no shows, and rescheduled appointments significantly impact the schedule. We always call to confirm your appointment, which should be sufficient time to know if you can keep your scheduled appointment or not.

It costs a lot of money to run a medical practice. Broken appointments, cancellations with short notice, and no shows not only significantly hurt our revenue, but also prevent us to provide our services to the patients in real need during those times. There have been several no shows and cancelled appointments in the past, which forced us to bring the following policy into effect:

If you are late without notification, we will have to reschedule your appointment at the next available time. There is a \$25 charge for any appointment changes or cancellations with less than 24 hour notice. No shows or Broken appointments without notice will not be rescheduled.

PATIENT CONSENT: MESSAGES AND APPOINTMENT REMINDERS PER HIPAA REGULATIONS

May we leave the following types of messages at your home/work/cell phone or emergency number?

- | | | |
|--|------------|-----------|
| 1. Office appointment changes/reminders | Yes { } | No { } |
| 2. Prescription refill information | Yes { } | No { } |
| 3. Lab and/or test results/appointments | Yes { } | No { } |
| 4. When authorization, medical records or physician script are required for upcoming appointment | Yes { } | No { } |

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE

As required by the Privacy Guidelines, I hereby acknowledge that I have received a current copy of Advanced Allergy & Asthma Care's "Notice of Privacy Policy", revision dated April 14, 2003. I have read the Privacy Policy and understand my rights contained in the notice.

By signing on this form, I provide Advanced Allergy & Asthma Care with my authorization and consent to use and disclose my information/my child's/ the patient for whom I am the legal guardian's protected healthcare information for the purposes of treatment, payment and healthcare operations described in the Privacy Policy.

I hereby read and agree with STATEMENT OF FINANCIAL RESPONSIBILITY, OUR OFFICE POLICY CONCERNING APPOINTMENTS, PATIENT CONSENT: MESSAGES AND APPOINTMENT REMINDERS PER HIPAA REGULATIONS and ACKNOWLEDGEMENT OF RECIEPT OF NOTICE as described above

Patient's Name: _____ Today's Date: _____
(Please Print)

Patient/Parent/Legal Guardian's Name (Please Print)

Patient/Parent/Legal Guardian's Signature

Authorized Facility Signature: _____ Today's Date: _____