Please Read, Call and Sign!

*When **you call** your health insurance company to verify your eligibility and benefits please ask about the following "codes" to see what the specific benefits are: **Please get a name of the person who quoted you, Date, Time and a reference number.***

95004- Allergy Prick Skin Test: Covered: **Yes** **No** Any limits? _____

95024- Intradermal (ID) Skin Test: Covered: **Yes** **No** Any limits? _____

95165- Allergy Serum (for "shots"): Covered: **Yes** **No** Any limits? _____

95117- Allergen Immunotherapy injections "shots": **Yes** **No**

95012 – Exhaled Nitric Oxide (ENO): Covered **Yes** **No**

Do **ANY** of the above codes go towards your deductible? **Yes** **No**

Please tell us about your deductible:

- What is your deductible? $_____
- Has it been met? **Yes** **No**
- What is the amount met? $_____

Do you have a HSA (Health Savings Account)? **Yes** **No**

Person's name you spoke with:_____ **Date:** _____

Time:_____ **Reference #** _____

- I am fully aware of my health insurance and I certify that the above statements are true.
- I understand that, if providing inaccurate information, I will be responsible for the cost of services provided.
- I have read and understand the Financial Policy and I fully agree with it.
- I understand and agree that (regardless of the insurance company); I am ultimately responsible for the balance of my account for any professional services rendered. I agree to pay any and all costs associated with the collections of this debt including, but not limited to interest at the current legal rate, collection agency fees, attorney fees and court cost as applicable.

Name: _____ Date: _____

LIST OF CURRENT MEDICATIONS

PATIENT: _____ DOB: _____

Please list all medications, even over the counter medications

Name of Medication	Dosage	How many times a day?

Missed Appointments

We require 24-hour notice of appointment cancellations. We reserve the right to charge for any appointments not cancelled or broken without 24-hours notice. (**$50** for a follow-up appointments and **$100** for new patient appointments) More than 3 missed appointments will result in termination of care.

Minors/ Dependants

Children under the age of 18 will require the signature of a responsible adult party on the registration form. We cannot treat unaccompanied minors on their initial visit. Non-emergency treatment will be denied unless payment by cash or check can be collected at the time of service.

Patient's Financial Responsibility

Methods of Payment

- Acceptable methods of payment are cash, check, credit card or money order.
- Any check returned by your back will incur a $35.00 fee in addition to any charges your bank may impose.

If no insurance is to be filed or if we are not a participating provider for your insurance, payment will be due at the time of service.

Co-payments, deductibles, non-covered services and outstanding balances are due at the time of service. Co-payments will be collected at check-in. Patients are responsible to know what their office visit co-pay amount is!

Accounts Past Due

Payment from statement is due upon receipt

Non-payment may result in preparation of account for collections bureau and discharge from the practice. If any account goes unpaid for a period of 90 days, it will be turned over to collections unless payment arrangements are made in advance. Any account sent to collections will result in that patient being dismissed from the practice.

Forms and Release of Records

The completion of administration forms about your case and duplication of medical records is not a part of your routine medical services from us. We are happy to assist you in any way we can, be we reserve the right to charge appropriately for these extra services, based upon the time and effort involved.

Forms

- A $15.00 fee will be charged for forms such as: FMLA, Disability, request for special equipment, letters to employers, etc.
- Forms and letters will be available to be picked up after 5 business days.

Release of Records

- Requests must be made in writing by filling out our Records Release Form.
- If you require us to copy your medical records, there will be a fee based upon the number of pages copied. Fees based upon Indiana State Law (IC16-39-9-3) are $0.25 per page, plus postage and $5.00 labor fee. If copies of records are picked up from the office, the postage fee will be waived.
- All fees must be paid prior to the transfer of medical records.
- Please allow 5 business days for records to be available for pick up or delivery.
- Law firms and insurance companies requesting records will be charged an additional $15.00 retrieval fee.
- There is no cost to provide records to facilities of physicians that we refer you to see.

Indiana Institute of Immunology, Allergy and Asthma, P.C.
2216 West Alto Road
Kokomo, IN 46902
Phone: (765) 450-6396
Fax: (765) 450-6354

Office and Financial Policies

Office Forms

A fully completed, current patient registration will be on file in the patient chart during the time the patient is considered an active patient.

- Patient registrations will be updated completely by the patient yearly so we have accurate information in order to contact the patient if necessary.
- **Social Security numbers are required for each patient, including minors.**
- Signatures by the responsible party are required.
- Your insurance card may be photocopied at **each visit.**

Account Consultation

Physicians do not discuss financial issues. Our billing staff is trained to discuss your account and can make payment arrangements if necessary.

Insurance Claims

You, the patient or adult responsibility party, are responsible to know and understand your insurance coverage. This includes verification that our physician is a provider within your insurance network.

Primary Insurance

- We will file a claim with the patient's insurance upon the patient's submission of proof of insurance (i.e. insurance card indicating coverage, identification number, group number and claims mailing address).
- If your insurance company does not respond to our claim within 60 days of the date of service, the balance due will become the patient's responsibility.
- In the event the patient has insurance coverage but cannot provide documentation, payment is due at the time of service. Upon submittal of insurance card, we will submit a health insurance claim form indicating patient payment at the time of service, so the insurance company will reimburse the patient. In the event the insurance company sends the payment to us, then we will refund the patient.
- If your insurance company does not pay for office visits or consultations, payments will be due at the time of service.

Secondary Insurance

- Secondary insurance is filed upon the patient's submission of proof of secondary insurance. However, if payment is not received in our office within 45 days after filling, the responsibility will be transferred to the patient and due upon receipt.

Referrals

Certain insurances require that you have a referral from your primary care physician to see a specialist. Please make sure that your physician has either called or faxed a referral to us.

- You are responsible for requesting the referral from your primary care physician. If you are not sure if the physician you are seeing is on your insurance plan, please contact your insurance.
- If we do not have the proper referral, you will be required to reschedule your appointment or pay for the visit at the time of service.

INIIAA- Indiana Institute of Immunology, Allergy, and Asthma, P.C.

2216 WEST ALTO ROAD KOKOMO, IN 46902-4840 Phone: 765-450-6396

About the Patient

Name:_____ Date of Birth: _____ SSN: _____

Home Address: _____ City:_____ State: _____ZIP:_____

Home Phone:_____ Work #: _____ Cell #:_____

Employer (name & address): _____

Primary Physician (name, address, phone): _____

Referring Doctor (name, phone): _____

Primary Health Insurance

Primary Insurance Company Name: _____

Primary Insurance Address: _____

Insured Name: _____ Date of Birth: _____ SSN#: _____

Policy:_____ Group: _____ Insurance Phone:_____

Secondary Health Insurance

Secondary Insurance Company Name: _____

Secondary Insurance Address: _____

Insured Name: _____ Date of Birth: _____ SSN#: _____

Policy:_____ Group: _____ Insurance Phone:_____

Spouse Information

Marital Status (circle one) SINGLE MARRIED DIVORCED WIDOWED SEPARATED

Spouse Name: _____ Cell Phone: _____ Work Phone: _____

Spouse Date of Birth: _____ SSN: _____ Employer: _____

Account Information- Person Responsible for Billing

Name: _____ Relationship: _____ Phone:_____

Billing Address:_____Employer:_____

EMERGENCY CONTACT ***(other than your home):*** _____

Relation: _____ **Phone:** _____ **Cell:** _____

- I request that payment of authorized MEDICARE benefits be paid to me or on my behalf to Dr. Damir Matesic for any services rendered. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.
- I authorize Dr. Damir Matesic to release any medical information to my insurance company or its agents to determine benefits payable. A photocopy of this authorization may be used in place of original.

SIGNATURE:_____ **DATE:**_____