**Montana Allergy and Asthma Practice**

**Financial Policy**

Effective June 1, 2025

We are committed to providing you with the best quality medical care. Questions and conversations about our professional fees are welcome at any time. The fees charged reflect the level of professional skill required, the complexity of the patient’s presenting complaints and medical history, and the time spent evaluating and treating you.

INSURANCE

Billing of insurance is a courtesy we provide to our patients and is not required by law. Please bring a copy of your current insurance card and photo ID at every visit and inform the front desk whenever there is a change in your insurance. We may occasionally ask for additional copies for our records. It is your responsibility to have knowledge of your annual deductible, co-pays, and out of pocket maximum. If your insurance company does not respond to us within 30 days of our submitting a claim, the balance will become your responsibility.

We will bill your primary insurance, and bill secondary insurance for any line item with a balance greater than $10. If you have balances smaller than $10, we ask that you pay us and submit claims to your secondary insurance for reimbursement. We do not bill tertiary insurance.

CARD ON FILE

We require a credit card on file at the time of scheduling. This helps streamline the check-in and check-out process. Your card information is securely stored and protected. By signing this form, you give us permission to charge the card no-show and cancellation fees, and to charge the card for any patient balance we have made 3 attempts to collect. Attempts may be made through the patient portal, mail, phone call or text.

CO PAYS

Your co-pay is determined by your insurance carrier. Your insurance contract requires that we collect your co-pay at the time of service when you check in to be seen. Please be prepared to pay your co-pay at each visit. **This applies to shot visits as well.**

REFERRALS and AUTHORIZATIONS

If your insurance plan requires a referral from your primary care provider, an authorization, purchase order, or “Passport Provider”, it is your responsibility to confirm that we have received it. If the referral is not complete, you may be required to reschedule, and/or the charges may become your full responsibility.

MISSED APPOINTMENT FEE & LATE CHANGE FEE

When you schedule an appointment, we set aside that time especially for you. Our providers and support staff are prepared to serve you at that time. Last minute openings are hard for us to fill.

We require 2 business days’ notice of your need to cancel/reschedule an appointment. There is a $250 fee for missed/no-show appointments. There is a $150 fee for canceling your appointment less than 48 business hours before your scheduled appointment.

patient initials

We understand that life is unpredictable- however, if you need to cancel or reschedule an appointment, let us know as soon as possible. This $250/$150 fee will not be billed to your insurance carrier; it is your responsibility and will be charged to the credit card on file. This fee applies to all patients, regardless of insurance provider or coverage status.

NSF FEE

A fee of $50 will be charged to your account if your check is returned for insufficient funds.

SELF PAY/UNINSURED

We will collect a $300 deposit on the day of your appointment before being seen by the provider.

The balance will be collected following your appointment, charged to your card on file. By signing below, you agree to let us charge the card on file for the balance in full.

HIGH DEDUCTIBLE PLANS

If you have not met your deductible, or do not know if you have met your deductible, we will collect a $300 deposit from you on the day of your appointment before being seen by the provider. The balance will be collected following your appointment.

ACCOUNTS WITH OUTSTANDING BALANCES

If you have an outstanding balance at the time of your appointment, we need to collect that balance, or a portion of that balance up to $200, before you may be seen by the provider or receiving services.

PAYMENT PLANS

Once you receive a statement from our practice, please pay in full upon receipt. For your convenience, we accept cash, personal checks, debit and credit cards and Care Credit to assist you in paying your balance in full. If you cannot pay your balance in full, a short-term automatic payment plan may be created to pay your balance over 3-6 months. You may be sent a letter stating the budget plan and the terms of repayment.

COLLECTIONS

We refer accounts to an outside collection agency if we fail to obtain payment through usual methods of mailing patient statements to the account guarantor. Please keep us informed of address and phone number changes to help us to stay in contact with you.

If your account is referred to our collection agency, any further visits to our practice will require your payment in full at the time of service. We will still bill your insurance for the visit and issue you a refund if necessary.

By signing below, you indicate your understanding that in the event any unpaid balance is placed for collections with any third-party collection agency, a fee of 33.333% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, late fees, and any other fees so stated elsewhere. The authorized fee of 33.333% and the additional costs and charges listed above represent the actual costs incurred by Montana Allergy and Asthma Practice to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from this signer’s failure to pay as specified in this agreement.

By signing below, I agree that I have read and agree to this financial policy.

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Patient/Responsible party signature Patient/Responsible party name, printed date