



**FINANCIAL POLICY / RECEIPT OF PRIVACY PRACTICES / LEGAL ASSIGNMENT**

All patients / legal representatives / guarantors are responsible for payment at the time of service. We accept cash, checks and most major credit cards.

If your insurance deductible is not met, we will collect a portion of it at the time of service until met. Thereafter, we will collect your co-payment only. Insurance co-payments are due at the time of service. If you have a co-insurance responsibility we will collect a portion of that at time of service. Co-insurance is based on a percentage, any balance still owing will be billed to you once we receive the Explanation of Benefits from your insurance company. If you have no insurance, or if we are not able to verify insurance eligibility full payment is due at the time of service.

Supplements and/or home health care products dispensed by our doctors and staff must be paid for on receipt unless prior arrangements have been made.

If your account is placed in collection status, all future services must be paid in full at the time of service. Any balance assigned to a collection agency will be assessed a 30% fee to offset the recovery expense.

**LEGAL ASSIGNMENT:** I, the undersigned, have health insurance and/or employee healthcare benefits coverage and hereby assign and convey directly to Allergy and Environmental Treatment Center, LLC all medical benefits and/or insurance reimbursement otherwise payable to me for services rendered to me by Allergy and Environmental Treatment Center, LLC, its officers, directors and/or employees ("AETC"). Notwithstanding the above, I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Allergy and Environmental Treatment Center, LLC to release any and all of my medical information as necessary to process my medical claims. Further, I agree to fully cooperate with Allergy and Environmental Treatment Center, LLC in its attempts to pursue my medical claims against my insurers and/or health care benefit plan as necessary, including bringing suit against any such insurer and/or health care benefit plan. This assignment will remain in effect until revoked by me (or by patient's legal representative or guardian) in writing.

**I have read and agree to abide by the above financial policy and Legal Assignment. I have also received a copy of the Notice of Privacy Practices:**

Patient Signature: \_\_\_\_\_

If a minor or incapacitated, name and signature of legal representative or guardian:

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**8600 E. Shea Blvd., Suite 110, Scottsdale, AZ 85260**  
**Phone (480) 634-2985**

## **NOTICE OF PRIVACY PRACTICES**

This notice describes how health information about you, as a patient of this practice, may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

### **Use and Disclosure of Your Health Information**

We may be required to use or disclose your health information:

1. If public health authorities and/or health oversight agencies authorized by law to collect information make a request for information;
2. With respect to lawsuits or similar proceedings in response to a court or administrative order;
3. When docketing a medical provider lien;
4. When your or a third party's insurance company and/or attorney submits a request for information;
5. If required to do so by a law enforcement official;
6. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to reduce or prevent the threat;
7. If you are a member of U.S. or foreign military forces (including veterans) and we are required to disclose by the appropriate authorities;
8. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official;
9. To Workers' Compensation or similar programs; and
10. To companies performing diagnostic testing services on your behalf.



## Notice of privacy practices, cont

### **Your Rights Regarding Your Health Information**

1. You may request that our practice communicate with you about your health and related issues in a particular manner or location. We will accommodate reasonable requests (i.e. home vs. work);
2. You have the right to request we do not leave information regarding your care and treatment, including but not limited to appointments, insurance and billing matters, with a particular individual or on a telephone answering or voice-mail system. However, **please note that we may leave messages for you with alternative sources regarding the above unless and until specifically directed by you in writing not to do so;**
3. You have the right to obtain a copy of your health information, including your medical and billing records, but not including psychotherapy notes. You must submit your request in writing to us at 8600 E. Shea Blvd., Suite 110, Scottsdale, AZ 85260;
4. If you believe your privacy rights have been violated, you may file a written complaint that clearly outlines the nature of the violation with our office or with the Secretary of the Department of Health and Human Services; and
5. Our office will obtain your written authorization for uses and disclosures not identified by this notice.

If you have any questions regarding this notice, please contact us at:  
Phone (480) 634-2985 or 8600 E. Shea Blvd., Suite 110, Scottsdale, AZ 85260