ALLERGY & ENVIRONMENTAL TREATMENT CENTER, LLC

PATIENT FINANCIAL POLICY

Thank you for choosing Allergy & Environmental Treatment Center, LLC (the "clinic") for your health care needs. The clinic is committed to building a successful relationship with you and your family. The patient financial policy has been developed to assist you to understand matters related to your responsibility for payment for health care services provided to you by the clinic. Please read the policy carefully and sign below to indicate your agreement to follow the Patient Financial Policy. Please feel free to ask the staff of the clinic any questions you may have.

1. **PROOF OF INSURANCE.** All patients are required to complete our patient information forms prior to any medical treatment by the clinic. It is the patient's responsibility to promptly update the clinic with any changes in address, employment, insurance, etc. Failure to provide us with this information may lead to denial of claims and cause you to be personally responsible for charges incurred. Patient is also solely responsible for knowing the terms and conditions of his or her medical insurance plan. **(______________) (patient initials).**
2. **FINANCIAL RESPONSIBILITY**. I understand that as the recipient of medical care, I am responsible for all charges regardless of my circumstances for reimbursement, and I agree to pay my account with the clinic in accordance with the regular rates and terms of the clinic. Full payment is due at the time of delivery of service or supplements and or health care products. I understand that certain insurance claims may be filed by the clinic as a courtesy to me. However, if a claim is denied for any reason, I am responsible for payment. **I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY ANY CO-PAY, DEDUCTIBLE, CO-INSURANCE OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE OR THIRD PARTY PAYOR WITHIN 30 DAYS OF THE DATE OF THE CLINIC'S STATEMENT TO ME. ___________ (patient initials).**
3. **ASSIGNMENT OF INSURANCE BENEFITS.** In consideration for services rendered, I hereby transfer and assign to the clinic all rights, title and interest to all medical benefits and or insurance reimbursement otherwise payable to me for services rendered to me by the clinic. I hereby authorize the clinic to release any and all of my medical information as is necessary to process my medical insurance claims. I also agree to cooperate with the clinic 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.
4. **DEFAULT**. If I fail to satisfy unpaid charges for more than 30 days from the date of the clinic's statement, interest on the unpaid charges shall accrue at the rate of 18% per annum from the date of service until paid in full. Unpaid charges over 60 days past due shall also incur a monthly late fee of $25. If I default and my account is referred to a collection agency or attorney, I will be responsible for all costs of collecting monies owed including interest, court costs, late fees and collection and attorney's fees equal to one-third of the outstanding balance due.

MY SIGNATURE BELOW CERTIFIED THAT I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS OF THE FINANCIAL POLICY.

Patient signature____

Date__________________________________