Carolina Asthma & Allergy Center
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Patient Financial Policy

Thank you for choosing Carolina Asthma & Allergy Center (CAAC) for your healthcare needs. Providing you with excellent medical care and service is our primary concern. Our goal is to provide care in a cost-effective manner. This includes our ability to collect amounts due efficiently. For this reason it is *imperative* that you be aware of our financial policies. Please read this policy thoroughly. If you have questions, call us by contacting our business office at 704-998-0812.

- Patient Payments: You agree to pay patient-due amounts, including co-pay, outstanding deductible, co-insurance, and outstanding balances. Through our partnership with HealthiPASS, we will collect your credit card or bank account information when you check in so that we can easily process any remaining balance you have after your insurance claim has been processed.

- Proof of insurance, changes in coverage, and identification**:** It is your responsibility to provide us with current insurance information, and to bring a photo Identification card and insurance card to each visit. If your insurance changes, please notify us so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim because of a change or lapse in insurance, any balance will automatically be billed to you. ***Prior to receiving your next shot***, you must inform us of any coverage changes.

- Claims submission: CAAC will submit your claims and assist in any way we reasonably can, to ensure that your claims are processed according to your benefits.

- Referrals: Your insurance company may require a specialist referral from your primary care provider (PCP) in order for you to see our physicians. ***It is your responsibility to obtain that referral prior to your appointment***. Should you arrive for your appointment without a *required* referral, it may be necessary to either reschedule your appointment or require that you pay directly for all services at the time they are rendered.

- Card on File Payment Plans: In an effort to simplify the payment process for our patients, we are introducing a convenient, highly secure, Credit/Debit/HSA card and Bank ACH Payment program for our patients.
    - If your insurance plan includes co-pays, deductibles and/or co-insurance, you will be required to provide a card-on-file (card/ACH based) assurance at the time of service (in addition to paying any outstanding balance).
    - We will provide you an estimate of your out-of-pocket costs, typically within 3-5 days after services have been delivered.
    - We will then file a claim to your insurance company. After the claim has been processed by your insurance company, we will send you an electronic bill for the final out-of-pocket amount due from

you including co-pay, co-insurance, and deductible, as applicable. After the notice period, your card-on-file will be charged the amount due, and an electronic receipt will be emailed to you.

- Missed Appointments: CAAC has a waiting list for appointments and requests that all patients be considerate of other patients when needing to cancel/reschedule an appointment. ***To avoid a possible $25 missed-appointment fee, a 24-hour notice is required for cancellations.*** If you need to cancel or reschedule your appointment, please call 704-372-7900 or via email inform us at least 24 hours before the appointment at: scheduling@carolinaasthma.com.

- Bad Debt/Collection Agencies: Patients who do not respond to CAAC's collection efforts on an overdue balance may be referred to an outside collection agency and be held responsible for collection agency fees. Patients with unpaid balances with a collection agency will be required to settle the balance prior to making appointments or receiving shots (except in the event of a medical emergency). Patients will also be held responsible for all fees associated with non-sufficient funds (NSF).

Please Read the Following and Sign

Assignment of Benefits: "I authorize and request payment of the medical and/or major medical benefits directly to my physician. This authorization will cover all medical services rendered until a written notice of cancellation is received in this office. I understand that:

- Amounts paid by my insurance company to my physician for specific services rendered may change from time to time.
- Payment amounts requested at checkout and/or insurance adjustments appearing on visit summaries and statements are ***estimates***.
- Upon receiving final accounting and payment from my insurance company, an additional payment from me may be required to settle my account.
- I am financially responsible to my physician for charges not covered or paid for by the Assignment.
- I authorize the release of any medical information necessary to process my insurance claims."

"**I have read and understand the Financial Policy as stated above, and agree to abide by the Carolina Asthma & Allergy Center payment policies."**

Patient Name _____ Patient/Guardian Signature _____

Date Signed _____

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PATIENT'S NAME: _____

Important Patient Information

- A patient *must be accompanied by a parent or legal guardian* unless he or she is legally and financially responsible for charges incurred in the course of treatment.
- Please notify our office at least five (5) days in advance if the patient will need a translator during the scheduled appointment.

APPOINTMENT INFORMATION

Time Scheduled: _____ ❑ AM ❑ PM Date Scheduled: _____

Your appointment is scheduled at

❑ Eastover - Main Office	2600 East 7th Street, Unit A	Charlotte 28204
❑ Ballantyne	14135 Ballantyne Corporate Place Dr, Suite 225	Charlotte 28277
❑ Concord	900 Branchview Dr NE, Suite 100	Concord 28025
❑ Cornelius	19475 Old Jetton Rd, Suite 100	Cornelius 28031
❑ Gastonia	2325 Aberdeen Blvd, Suite C	Gastonia 28054
❑ Huntersville	15940 Northcross Drive, Suite C	Huntersville 28078
❑ Monroe	Building B – The Park at Monroe 1995 Wellness Blvd, Suite 200	Monroe 28110
❑ Mooresville	311 Williamson Road, Suite 100	Mooresville 28117
❑ Rock Hill	197 Piedmont Blvd, Suite 109	Rock Hill, SC 29732
❑ South Park	5970 Fairview Road, Suite 500	Charlotte 28210
❑ University	8401 University Executive Park Dr, Suite 128	Charlotte 28262
❑ Waverly	11840 Southmore Drive, Suite 175	Charlotte 28277

➔ For directions please check our web site at www.carolinaasthma.com or contact us at 704-372-7900

Vitally Important Visit Information

- Please arrive at your scheduled time. If you are more than 15 minutes late for your appointment, you will be asked to re-schedule at another date and time.
- Regarding Authorizations or Referrals: If you have TriCare Prime, V.A. or any of the HMO or POS plans, an authorization or referral is required prior to seeing a specialist. Please contact your insurance carrier to confirm. If a referral is needed, ask your primary care, OB/GYN, or internist to forward the information prior to your scheduled visit.
- As a courtesy to our patients Carolina Asthma and Allergy Center calls new patients at least one week prior to the scheduled visit to confirm their appointment. If you should need to cancel your appointment you must provide at least a 24-hour notice. Please call 704-372-7900 to avoid a $25 missed appointment fee.
- Do not wear heavy perfume or colognes as they may be irritating to our allergy patients.
- Do not bring food into the waiting room, as the contents could trigger an allergic reaction in our allergy patients.
- Be prepared to pay your co-pay listed on your insurance card at the time of service.

Self-Pay Patients and Patients with High Deductible Plans

Self-pay patients and patients with high deductible plans are responsible for all charges incurred at CAAC and are expected to pay in full at the time of service. If you have any questions or concerns, please call us at 704-998-0812 prior to your appointment.

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Special Antihistamine Medication Instructions

Many antihistamine medications interfere with skin testing. Below is a list of antihistamines to avoid prior to testing. (Never stop any medications without first checking with the prescribing physician.)

(Please ask your prescribing doctor for clarification of Antihistamines)

Five (5) days prior to your skin testing appointment:

Stop antihistamines such as: **Alavert**, **Allegra** (*fexofenadine*), **Clarinex, Claritin** (*loratadine*), **Dallergy, Xyzal** (*levocetirizine*), and **Zyrtec** (*cetirizine*). **Astelin** (*azelastine*), **Astepro** and **Patanase** nasal sprays will also need to be stopped.

If you are taking **Doxepin**, this also should be discontinued five days prior to skin testing.

Antihistamines such as: **Actifed**, **Aerohist**, **AlleRx**, **Arbinoxa** (*carbinoxamine*), **Atarax**, **Chlor-Trimeton** (*chlorpheniramine*), **Dimetapp** (*brompheniramine*), *hydroxyzine*, **Palgic** (*carbinoxamine maleate*), **Phenergan** (*promethazine*), **QDall**, **Tavist** (*clemastine*), **Tussionex,** and **Vistaril**.

If your symptoms are unbearable, you may use **Benadryl** (*diphenhydramine*) up to (3) days prior to visit.

Discontinue any antihistamine-containing eye drops such as **Alaway** (*ketotifen fumurate*), **Bepreve** (*bepotastine besilate*), **Claritin Eye** (*ketotifen*), **Elestat** (*epinastine HCl*), **Emadine** (*emedastine difumurate*), **Lastacaft** (*alcaftadine*), **Naphcon-A** (*naphazoline HCl*), **Optivar** (*azelastine HCl*), **Pataday** (olopatadine HCl), **Patanol** (olopatadine HCl), **Visine-A** (*naphazoline HCl*), **Zaditor** (*ketotifen fumurate*), and **Zyrtec Itchy Eye** (*ketotifen fumurate*),

There are multiple prescription and non-prescription combination medications that contain an antihistamine, please check the ingredients. You can also check with your pharmacist or our office for assistance.

- You may continue all **non-antihistamine** eye drops.
- Asthma medications should be continued, as they do not interfere with testing.
- Please bring all medications (including over-the-counter and vitamins) with you.
- For your convenience and to avoid delays, we encourage you to complete your new patient paper work in advance. Please visit our website at carolinaasthma.com where you can retrieve the new patient documents to be completed, as well as the directions to our offices.
- Please arrive at your scheduled time. Remember also to bring your insurance card and be prepared to pay your co-pay at check-in.
- Please allow up to three (3) hours for your initial appointment.

We look forward to seeing you. Should you find that you are unable to keep this appointment, please contact our scheduling department at **704-372-7900** or E-mail our office at appointments@carolinaasthma.com at least 24 hours in advance, to avoid the $25 missed appointment fee.

Thank you.

The Carolina Asthma and Allergy Center Team

CLEAR FORM

Carolina Asthma & Allergy Center

Consent For Release Of Protected Health Information To Family

Patient's Name: _____

History No.: _____

DOB: _____ M F

Today's Date: _____

"I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment for my care. List family members' names.

1)_____ 2)_____ 3) _____

(Check all that may apply):

- ❑ All my medical information
- ❑ Information necessary to schedule appointments for me
- ❑ Lab or test results
- ❑ Information necessary to provide, call in or pick up prescriptions for me
- ❑ Information necessary to help my family member(s) take care of me
- ❑ Information necessary to allow my family member(s) to pick up or arrange for medical equipment to be provided for me
- ❑ Information necessary to bill for or submit claims for care provided to me to government or private insurance payors.

❑ I give permission for CAAC to leave messages on voicemail regarding all information checked above, and regarding answers to any phone call questions I may have asked.

"My consent will remain in effect as long as I am a patient of Carolina Asthma and Allergy Center, PA, (CAAC) unless and until I notify CAAC in writing of any changes."

_____ _____

Signature of Patient or Representative Date

_____

Relationship of Representative to Patient

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Dear Prospective Patient:

We are so pleased that you have chosen Carolina Asthma and Allergy Center (CAAC) to care for your asthma and/or allergy condition. In order to provide the best possible care, we request that you retain a primary care physician (PCP) for your general health problems. As a team (your PCP, our physicians, and our staff), we will work together to care for your asthma and allergy problems, but we do feel that your PCP is better equipped to treat your other illnesses. This creates optimum health care.

We have listed below some suggestions to enhance the quality of your experience with obtaining care at CAAC.

1. Contact your insurance company to determine:

   a. If Carolina Asthma & Allergy Center is in your insurance network. **If we are not, you may be responsible for any or all charges for services rendered.**

   b. If we are in your network, does your policy cover reimbursement for specialist consults, allergy testing, and allergy vaccines/injections?

2. Bring any medical records from your primary care physician or specialist(s) which you feel might be helpful to us in our assessment and treatment of your condition. Please inform your primary care physician that CAAC can now accept electronic Continuing Care Documents ("CCD"s). They can send the electronic CCD directly to your CAAC physician so that your primary care electronic health record can be imported into our electronic health record system. This reduces duplicate work and helps improve quality of care.

3. Please complete all of the enclosed forms prior to your visit.

Office Schedules

As you have chosen a particular CAAC office at which you wish to be seen, please familiarize yourself with the days of the week and the hours that specific office is open. This is especially important to our "shot" patients because of the limited days and hours available for your scheduled shots.

Our dedicated nursing triage staff is available Monday through Friday, 8AM to 5PM, and is available to answer clinical questions by calling 704-372-7900. One of our Patient Attendants will take your question and document it in your electronic health record. A nurse will return your call after researching it and possibly conferring with your physician. Please note that, depending on call volume and the time of day you call, you may have to wait until later in the day or the next business day for the staff to be able to return your calls to answer your questions.

Our physicians are on-call for emergencies between 8 AM and 11 PM seven days a week. For non-emergency situations, we have provided a voice message that allows you to leave pertinent information regarding your situation which will be taken care of on the next business day.

Refills

Calling the pharmacy where you had the original prescription filled is the very best way to obtain refills of your allergy and asthma medications. Typically, we will write the original prescription for multiple refills and that will be on record at your pharmacy. Should there be no further refills, your pharmacy will call our office; we will review your record, and again give multiple refills, ***if you have routinely been seen in our office***. (Due to the nature of our practice, other than an occasional cough preparation, we do not routinely prescribe narcotic medications.) If you are in need of new medications, please request them during regular business hours

Follow-up Care

Your compliance is crucial to the success of your allergy program. Your allergist will advise you as to when you should return to discuss your progress. If at all possible you should schedule your return visit at the time of checkout. Depending upon your individual case, you may be asked to return anywhere from two weeks to 12 months.

If you are ill, rather than just walking-in, please call the office first and discuss your situation with the triage nurse. S/he may request that you come in to see the doctor or our physician's assistant. Please note that our physicians prefer not to prescribe antibiotics without having first examined our patients.

We appreciate your following these guidelines and assisting us in realizing our goal of providing you with the best available allergy and asthma health care.

Sincerely,

CAAC Physicians & Staff

Encl(s)

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Medical Record Requests and Patient Completion Forms Policy

North Carolina law requires that a provider furnish copies of medical records to a patient within 30 days from receipt of the initial request. Additionally, the provider is allowed to charge a reasonable fee for copying and postage.

Carolina Asthma & Allergy Center will complete patient medical forms as follows:

School Forms and Skin or Lab Test Requests

1. **No fee** will be charged for:
    a) The completion of school forms such as school medical or college health forms.
    b) Skin and lab test requests will be given to the patient for free.

2. **Prior to your office visit** the form should be given to the Front Desk Staff and will be completed and returned to you by the Clinical Staff during the visit.

3. Carolina Asthma & Allergy will make best efforts to send your medical records to you in the format requested as long as it's in a secure manner. Fax requests will only be sent to a designated recipient. It is our policy not to send medical records via email.

Life Insurance Claims, Disability Forms, Attorney Requests, Family Medical Leave Of Absence (FMLA) Forms, and Medical Record Requests

These forms will be completed and/or medical records requested will be sent after the following fee is paid.

In accordance with the NC general statute 90, Carolina Asthma & Allergy requires the following amounts be paid. The maximum fee for each request shall be:

- Seventy-five cents (75¢) per page for the first 25 pages,
- Fifty cents (50¢) per page for pages 26 through 100, and
- Twenty-five cents (25¢) for each page in excess of 100 pages.

All Forms Received By Mail or Dropped Off At Our Office

Carolina Asthma & Allergy Center will make best efforts to complete and return these to the patient or parent, within fifteen (15) business days but not greater than thirty (30) days.

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PROTECTED HEALTH INFORMATION

CONSENT TO THE USE AND DISCLOSURE

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by the Carolina Asthma and Allergy Center or disclosed as per Federal guidelines for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. The Carolina Asthma & Allergy Center will practice according to our Privacy Policy.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. Carolina Asthma and Allergy Center may or may not agree to restrict the use or disclosure of your protected health information. If Carolina Asthma and Allergy Center agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Reservation of Right to Change Privacy Practices

Carolina Asthma and Allergy Center reserves the right to modify the privacy practices outlined in the notice.

"I have reviewed this authorization form and give my permission to Carolina Asthma and Allergy Center to use and disclose my health information in accordance with it."

Name of Patient (Print or Type)	Signature of Patient	Date Signed
Signature of Patient Representative	**Relationship of Patient Representative to Patient**	

Carolina Asthma & Allergy Center

Date _____/_____/_____ History No.: _____

Patient Information	Race:	Ethnicity:	Preferred Language:	
	Mr.	Ms.	Mrs.	Dr.
	First	MI	Last	
Street Address			E-Mail Address	
Mailing Address				
Zip		City		State
Phone		Date of Birth		
SS#		Gender M ❑ F	Marital Status	
Occupation				
Employer			Employer Phone	
Address				
Zip		City		State
Family Doctor				
Address				
Zip		City		State
Referring Doctor				
Address				
Zip		City		State
RESPONSIBLE PARTY	Mr.	Ms.	Mrs.	Dr. DOB:
	First	MI	Last	
Street Address				
Mailing Address				
Zip		City		State
Phone	Home	Work	SS#	
Employer			Employer Phone	
Address				
Zip		City		State
Relationship to Patient				

PATIENT REGISTRATION FORM (Please Turn Over)

Insurance Information	Insured's Name	First	MI	Last	DOB

PRIMARY Insurer			
Mailing Address			
Zip	City		State
Policy No.	Group No.		Plan

Insurance Information	Insured's Name	First	MI	Last	DOB

SECONDARY Insurer			
Mailing Address			
Zip	City		State
Policy No.	Group No.		Plan

EMERGENCY NOTIFICATION NEXT-OF-KIN (not living with patient)

Name			
Address			
Zip	City		State
Phone	Home	Work	

PARENTS OF MINOR PATIENTS – NOT LISTED AS RESPONSIBLE PARTY

Name		Mother ❑	
		Father ❑	
Address			
Zip	City		State
Phone	Home	Work	

How did you hear about us?

❑ Friend ❑ Family ❑ Internet ❑ Advertisement ❑Physician ❑ Other

AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE COMPANY

"I authorize the release of any medical information necessary to process my insurance claim."

Signed: Responsible Party _____ **Date**_____