ADVANCED ALLERGY & ASTHMA CARE, PA
Dr. Rima Sanka, DO Dr. Latha Chamarthy, MD Dr. Ami Degala, MD
Tel: (727) 544-8100 Fax: (727) 544-8200 www.allergydoc.us

STATEMENT OF FINANCIAL RESPONSIBILITY

As a courtesy to you, our office will submit claim(s) to your Health Insurance Carrier(s) for the services provided to you or your covered family members.
You will be responsible for any and all Co-Payments, Deductibles and for charges not covered by your health insurance carrier(s). All payments are due at the time of service based on available information.
If no payment is received from your insurance carrier(s) within 90 (ninety) days from the date of service, the bill becomes your responsibility. Our office will bill you for the amount owed. In the event your insurance carrier(s) denies payment to the claim(s) or pays only partial payment, the bill becomes your responsibility.
In the event your insurance carrier(s) send payment to you directly, you agree to pay that amount immediately to our office.
Should the account be referred to a collection agency, the undersigned shall be responsible for an additional $50.00 collection cost plus any applicable attorney fees.

OUR OFFICE POLICY CONCERNING APPOINTMENTS

Drs. Chamarthy, Sanka, and Degala limit the number of appointments they make on a daily basis so that they can spend adequate time with each patient to provide the highest quality of medical care. Short notice cancellations (<24 hours), no shows, and rescheduled appointments significantly impact the schedule. We always call to confirm your appointment, which should be sufficient time to know if you can keep your scheduled appointment or not.
Broken appointments, cancellations with short notice, and no shows not only significantly hurt our revenue, but also prevent us from providing our services to the patients in real need. The following policy will be enforced.

If you are late without notification, we will reschedule your appointment to the next available time. If you no show, cancel your appointment or try to reschedule your appointment on the day of your appointment
There will be a $25.00 charge prior to scheduling your next appointment. A total of 3 no shows will result in termination from the practice.

I hereby read and agree with the STATEMENT OF FINANCIAL RESPONSIBILITY and OUR OFFICE POLICY CONCERNING APPOINTMENTS,as described above:

Patient's Name: _____ Today's Date:_____
(Please Print)

_____ _____
Patient/Parent/Legal Guardian's Name (Please Print) Patient/Parent/Legal Guardian's Signature

Authorized Facility Signature: _____Today's Date:_____

HIPAA Patient Questionaire

1. Please list the family members of other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

		Check if to contact ONLY in an **Emergency**
Name:_____	Ph Number:_____	☐
Name:_____	Ph Number:_____	☐
Name:_____	Ph Number:_____	☐
Name:_____	Ph Number:_____	☐

Print the address of where you would like your billing statements and/or correspondence from our office to be ***sent if other than your home.*** **(Confidential Communications)**

Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

Yes ☐ No ☐
I understand the Privacy Protection Act and have been offered a copy of the Organization's Notice of Privacy Practices updated for the HITECH Omnibus Rule of 2013.

Signature: _____ Date:_____