

Pacific Allergy & Asthma  
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### **Financial Policy**

In order to accommodate the needs and requests of as many patients as possible, Pacific Allergy & Asthma is contracted with numerous insurance companies. While we are pleased to be able to provide this service to you, it is not possible for our staff to keep track of all the individual requirements of each plan. Every plan has different stipulations regarding access to care and payment for services received. Providing quality medical care for our patients is our primary concern.

**Self-Pay Patients:** If you are a self-pay patient, you are 100% responsible for all charges associated with your treatment. You will be expected to make payment in full at the time of service.

**Outstanding Obligations :** You may be required to settle all outstanding financial obligations before new appointments are scheduled or office services are performed. Pacific Allergy & Asthma reserves the right to discharge a patient from the practice for non-payment of services.

Our continued participation in your health plan depends upon everyone fulfilling his/her obligation in accordance with our contracts. As a service to our patients, we obtain a description of benefits from your insurance. This office is not responsible for incorrect benefit information given to us by your insurance carrier. A description of benefits is not a guarantee of coverage and cannot be relied upon as such. In the event of non-payment by your insurance company, the charges incurred will be your responsibility.

Patients are responsible for all deductibles, co-payments, coinsurance, and non-covered charges. Payment is due at the time services are rendered. We accept Visa, MasterCard, Discover, American Express, Personal Checks, and Cash for your convenience. If you want to verify insurance benefits quoted yourself, please contact your insurance company.

If it is necessary to refer you to another physician you will want to verify with them that they are indeed providers under your plan. As a sub-specialist, we are not authorized to make referrals if required by your insurance plan. These must be obtained from your primary care physician.

If your insurance coverage changes to a network with which we are not associated, you may wish to determine if you have "out of network" benefits. This will allow you to continue to receive your care from us with altered financial coverage.

Returned checks will incur a \$30 service charge. You will be asked to bring cash, certified funds, credit/debit card or a money order to cover the amount of the check plus the \$30 service charge. All outstanding charges must be paid prior to receiving future services.

Late cancellation and rescheduling fees: You may be charged a \$50 fee for insufficient notice, if you cancel or reschedule your appointment or procedure less than 48 business hours in advance.

No show fees: You may be charged a \$50 fee for not showing for your office visit or procedure.

**Please present your insurance card at each visit. Please do not forget to notify of changes involving your insurance, name, or address. You are responsible for any charges that may be denied due to cancelled coverage.**

Patient Consent: I hereby give consent for such medical treatment for myself or I am duly authorized by the patient and his/her general agent to consent for such treatment.

Assignment of Benefits: I hereby authorize payment for medical benefits directly to Pacific Allergy & Asthma for services rendered. Release of Information: I hereby authorize the release of any medical information necessary to process any insurance claims.

**Patient name:** \_\_\_\_\_

**Who is signing and relationship to patient:** \_\_\_\_\_

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