Pavan Nataraj, MD
dmvallergy.com

Payment Acknowledgement/Financial Obligation

Your clear understanding of our policies is essential to our professional relationship. We are pleased to discuss and answer questions/or concerns regarding our policy, fees, and your financial responsibility at any time requested.

First Name: _____ Last Name: _____ DOB: _____

I understand, accept responsibility, and agree that:

- **By law,** we must collect co-pays/coinsurance and unmet deductibles. Co-pays/coinsurance and balances over $50 are due before services are rendered. If payment is not made, services may not be granted.
- Self-pay patients are required **at the time of service** unless other financial agreements have been made before your visit.
- I must give 24 hours' notice to cancel or reschedule. I will be charged a $75 no-show/late cancellation fee if I cannot provide notice.
- **If my account is placed with a collection agency, I will be charged an additional 30% of the total balance due, for which I will be responsible.**
- I am responsible for paying a return fee and the dollar value of any return checks from my financial institution.
- If an allergy serum has been filled (consent form) without one month prior **written notice** to discontinue, then I will be responsible for the cost of the serum. **Verbal discontinuation of serum is not permitted.**
- **In/out of network plans: It is my responsibility to verify my benefit coverage, and I'm responsible for any balance my plan indicates and an explanation of benefits.** If we do not participate in your plan, we will send a courtesy bill to insurance on your behalf. However, should you not pay your claim, you will be responsible for the total amount due payment to my insurance carrier. I agreed to forward the payment to DMV Allergy and Asthma Center.
- A referral is required by my PCP; it is my responsibility to obtain one prior to my appointment to bring in the day of service. If I do not have a referral, a signed referral waiver is required, which states that **I will be responsible for any service received and not pre-authorized.**
- Divorced/separated parents of minor patients: **DMV Allergy and Asthma Center will not be involved with separation disputes**.
- I understand there's a **per-page** fee for medical records and medical forms for school/sports/daycare providers/FMLA, etc.

Patient/Guardian Name (Print):_____ Date: _____

Patient/Guardian Signature: _____ Patient Date of Birth: _____

Relationship to Patient: _____