Welcome to the **ALLERGY & ASTHMA DIAGNOSTIC OFFICE.**

Thank you for taking the time to review and return the enclosed papers. **Upon receipt of the enclosed forms in our office, after they have been reviewed, we will contact you to schedule a New Patient Appointment**.

Dr. Juan Sotomayor is specialty trained and Board Certified in Allergy & Clinical Immunology and Pediatrics. We have Nurse Practitioners, Jill Agne, FNP, Summer Goetz, FNP, Katie Klee, FNP and Anna Salvagno, FNP to assist in seeing patients. Our patients are requested to have a primary care physician. We treat patients from infant up to age 64.

Please let us know if you have any questions or concerns. We are here to assist you. Thank you.

LOCATION: 5229 Witz Drive, North Syracuse, NY 13212 (315) 701-9500 FAX: (315) 701-9555

Please visit us on our website: www.allergyaway.com
EMAIL: patients@allergyaway.com

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APPOINTMENTS:

- **We require a 24-hour notice for all appointment cancellations.** Please refer to the "Notice of Cancellation Policy and No-Show Fee for Appointment" sheet for additional information.
- At your first appointment, you will be given specific instructions on our "Testing Appointments Policy".
- **Please be sure to read through all enclosed paperwork as there are medication instructions necessary for testing.** We may have to reschedule testing for a later date should these directions not be followed.
- Any patient *under the age of 18 years* must be accompanied by a parent/guardian (or written consent from parent) for ALL appointments. **The parent(s), guardian(s) and/or adult accompanying a minor is responsible for providing current insurance information for the minor and/or payment in full of any co-pay, co-insurance, deductibles due at the time of service.** Please be aware that we do not get involved in any child custody and/or divorce decrees.
- ******Reminder appointment phone calls are a courtesy to the patient. Please understand it is your responsibility to know when your appointment is.***

EMERGENCY COVERAGE: Our providers will be available after hours through our answering service for ***emergency calls only***. ***PLEASE NOTE: ROUTINE PRESCRIPTION REFILLS WILL NOT BE DONE AFTER OFFICE HOURS***

INSURANCE & FINANCIAL INFORMATION: Please verify with our office staff if we participate with your insurance as participation status could change periodically. Our office does **not** participate with Medicare, Medicaid, UHC government products and *Excellus* ***government*** programs, Total Care, WORKMAN'S COMP.
NYS Marketplace: Our office accepts Commercial Excellus BCBS plans and Fidelis Metal Level Products ONLY from the Marketplace/Exchange. **Any other Marketplace plan is not accepted. *****If your insurance changes to one of the products (including Secondary coverage), you must notify our office immediately.* ***If you are seen in our office with a Marketplace insurance in which we do not participate, the charges will be considered self-pay.*** Please understand that payment of your bill is considered part of the treatment. (Please see other side for our Financial Policy) It is your obligation to understand what is covered under your insurance plan.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MEDICAL RECORD REQUESTS: The Allergy & Asthma Diagnostic Office is committed to protecting patient's medical information. Since your medical records are confidential, your written authorization is required to obtain them. Please allow 10 business days for processing and paper copies for records are $.75 per page.

PLEASE READ & SIGN OUR FINANCIAL POLICY ON THE OTHER SIDE. →→→→→→→→

ALLERGY & ASTHMA DIAGNOSTIC OFFICE FINANCIAL POLICY

If you have medical insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.
We require a copy of ALL insurance identification cards and ask that you bring them with you and present them at EACH visit. (Insurances with individual cards, we must have the *patient's* ID card)
In addition, in an effort to prevent insurance fraud, our office requires all patients (guardians) to have a photo ID on file.

It is the patient's responsibility to secure ALL referrals if your insurance carrier requires one! If a referral is **NOT** in place **PRIOR** to your office visit, we may be forced to reschedule your appointment. We reserve the right to charge for a visit that needs rescheduling due to non-compliance.

Please verify with your insurance carrier if we are *participating providers* for your insurance. Many insurance provider directories are not up to date. We must emphasize that as medical care providers, our relationship is with you, not with your insurance company. All charges are your responsibility from the date the services are rendered. It is therefore, neither our place, nor our policy to contact insurance companies to establish why they have not made payment or why payment is less than the submitted charges. If an insurance carrier has not paid within 60 days of billing, any unpaid professional fees are due and payable from you. We encourage you to ask for an estimate of the charges you will incur *prior* to your visit.

PLEASE NOTE: For those insurance companies with whom we have a contract, ***all co-payments are payable at the time of the visit***; otherwise a $20.00 billing fee will *automatically* be added to your account.
****Please be prepared to pay for High Deductible Plan charges and co-insurance at the time of service.**
**We accept cash, check, Visa & MasterCard*

- **We will submit for most insurance's providing:** ***(we do not treat Workman's Comp, Medicare or Medicaid patients)***
  - The patient information form is *completely* filled out and appointment & financial policies signed
  - We have a copy of the *patient's* insurance identification card
  - We are able to verify coverage with your carrier and have a complete mailing address
  - If it is your Primary Insurance (we do not routinely bill non-participating secondary insurance's)
  - For non-participating insurances, excluding Tri-Care, we submit claims as a courtesy to our patients.
- You will receive a billing statement for any unpaid balances, co-insurance or charges determined not covered under your policy. **A $5.00 monthly billing charge will be added to all accounts over 30 days**. Any disputes with balances due **must** be brought within 30 days of the 1st billing or they will not be considered. Accounts not paid within 3 billing cycles, will be sent to collection and you will be responsible for collection fees.

- **We realize that temporary financial problems do occur and we encourage you to contact us promptly for assistance in the management of your account. Payment arrangements may be extended in the event of unusual circumstances. To avoid any misunderstandings, we invite you to discuss any financial problems with the Billing office.**

(REV: 03-2023)

ASSIGNMENT OF BENEFITS:

I have read, understand and agree to the AADO Financial Policy. I authorize the release of any medical information necessary to process my insurance claim(s). For participating insurances, I authorize and request payment of medical benefits directly to my physicians. I agree this authorization will cover all medical services rendered until such authorization is revoked by me. ***I understand that No-Show fees are considered a non-covered service and must be paid in full prior to any further appointments being scheduled. I also understand that supplies purchased in this office are considered non-billable to the insurance company and are due at the time of service.***
I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered and any fees incurred on my account. I will notify you of any changes in my health status or any changes in my insurance status. In the event my account is assigned for collection, I understand that I will be contacted by AADO collection agency of choice and I agree to pay an additional collection fee- the greater of-$25.00 fee or 30% collection fee based on the total amount due as well as any associated attorney fees.

SIGNATURE	DATE	PATIENT'S NAME (printed)	DATE