

**Daher Asthma and Allergy Clinic PLLC**

**PATIENT FINANCIAL POLICY**

**Updated as of January 1, 2026**

**Insured Patients**

As your medical provider, our relationship is with you, not your insurance company. As a courtesy, we will file your insurance claim for you. However, if your insurance company does not respond and pay the claim within sixty (60) days, you will be expected to follow-up with your insurance company. You are responsible for any amount your insurance does not pay. If you are uncertain about your health insurance policy benefits, you should contact your health plan to learn the details about your benefits, out-of-pocket expenses, and coverage limits. We attempt to verify coverage for services we provide, but we cannot guarantee what your policy will cover.

All co-payments, deductibles, coinsurance, and any outstanding balance from previous visits are due in full at the time of service. You will be billed for any additional amounts due after your insurance company pays its portion of the charges. If your company requires pre-certification/pre-authorization prior to your services, it is your responsibility to ensure that the insurance company's requirements are met prior to services being performed. If your insurance company denies charges due to a failure to meet pre-certification/pre-authorization requirements, you will be responsible for the denied charges. If you inform us of the pre-certification pre-authorization requirements prior to receiving services, we will gladly assist you in obtaining pre-certification/pre-authorization.

You must inform us of any changes regarding your insurance and provide us with new insurance card. You must also inform us of any address change, name change, or other change which may affect your insurance billing.

BlueCare is the ONLY MEDICAID we accept. You must notify us if you have Medicaid as secondary insurance.

**Uninsured or Self-Pay Patients**

A minimum deposit of \$200.00 or the actual charges, whichever is less, is due at the time of service for all self-pay patients. If the actual charges exceed \$200.00 and you cannot pay in full at the time of service, you will need to speak with the billing office to set up a three-month payment plan. **Credit card on file is required.**

If you have insurance but are choosing to exercise your HIPAA right to pay out of pocket, you must complete the HIPAA Restriction Request Form and pay all charges in full at the time of service.

**Methods of Payment**

We accept: 1) Cash 2) Check 3) Mastercard, Visa, Discover, Care Credit and American Express credit cards. A fee of \$30.00 will be charged for all returned checks.

**CREDIT CARD ON FILE IS REQUIRED FOR ALL PATIENTS**

**No-Show/Cancellation Policy**

There is a fee of \$50 for all No-Show appointments and for all appointments not cancelled within 24 hours of their scheduled time.

**Collections**

If you do not make payments to your account and you do not contact our office to make financial arrangements, your account may be assigned to a collection agency after sixty (60) days of no payment on the account.

If your account is placed with an outside collection agency, your balance will need to be paid in full with the collection agency before you may receive services from our clinic. A collection fee of up to 33 and 1/3% will be added to your account and shall become a part of the total amount due. You will be responsible for all collection fees, attorney's fees and court costs.

We reserve the right to dismiss you as a patient from our clinic due to unpaid bills.

Services will not be provided to any family member on the account under guarantor until balance has been paid.

**Cost of Form Completion**

Due to the time and complexity of completing various forms, such as Family Medical Leave Act (FMLA) and School Forms, and letters for Disability Applications, you may need to pay a fee (not to exceed \$40.00) for the completion of such paperwork. You will be informed of the cost, and the amount must be paid prior to the completion of the paperwork.

**Services for Minors**

For all services rendered to a minor patient (under age 18), the adult accompanying the minor patient is responsible for the payment of the charges, unless other arrangements have been made in advance with the billing office.

**Assignment of Benefits and Responsibility to Pay**

I hereby assign all medical benefits to which I am entitled and authorize and direct my insurance to issue payment directly to Daher Asthma and Allergy Clinic, PLLC for medical services to myself and /or my dependents. I have read and understood this financial policy, and I agree to be bound by its terms. Any questions I had were answered to my satisfaction. These are the terms and conditions that will apply to the patient's visits until such time as the policy is updated again and the clinic reserves the right to update the policy from time to time.

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Signature of Patient (or responsible party)

\_\_\_\_\_  
Print Name of Responsible Party

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_ Date \_\_\_\_\_

**Credit Card on File Form**

Daher Asthma and Allergy Clinic require all patients to keep credit card on file. This permits for smoother transaction and billing for our patients and ensures that Daher Asthma and Allergy Clinic can collect for services rendered in a timely manner. By simplifying payment, we can devote our energies to delivering exceptional patient care.

The credit card must be in the name of the patient or patient’s authorized representative.

**Credit card disputes:** Contact our billing department if you have a dispute or cancellation.

**Change in credit card information:** Patients are responsible for keeping their credit card information up to date and current with an active card. The consequences of failing to do so are the responsibility of the patient.

**Security**

DAAC takes the security of patient information including financial information seriously. All credit card information is held on a secure encrypted site in the EMR. No financial information is fully visible to staff or present in the office.

**Please include preferred monthly deduction amount from your credit card on file for any existing balance**

**Remember:** In compliance with our insurance contracts all copays are collected at the time of service.

**As a courtesy we submit your subsequent bill to your insurance company . The final charge would be what your insurance company indicates you owe base on DAAC carrier fee schedule.**

By signing the policy, I authorize Daher Asthma and Allergy Clinic PLLC to keep a credit card on file with DAAC I agree that the credit card on file can be used to pay for unpaid balances, fees and charges on the account. I confirm I am personally responsible for keeping my credit card information current.

I agree to charge my card .

Patient Signature (or Parent): \_\_\_\_\_

**Amount Approved: \$ \_\_\_\_\_ . \_\_\_\_\_ or Total amount (circle) to be drafted every 30 days**