



AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO FAMILY MEMBERS AND FRIENDS

Patient Name _____ Date of Birth ____/____/____

I hereby authorize Allergy, Asthma and Immunology Associates, P.C. (AAIA) to release my patient health information as described below:

(check one or both)

Name	Relationship	Medical	Billing	Phone Number

Protected Health Information (PHI) may include information/documents regarding medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointment and test results; accounting and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third party financing.

I understand that the Health Insurance Portability and Accountability Act of 1996, and its impending regulations (HIPAA) govern the terms of the Authorization. I understand that I have the right to revoke this Authorization, at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions, the right to revoke and the description of how I may revoke this Authorization is set forth in AAIA's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature; and that I should send it to the attention of HIPAA Compliance Officer".

I understand that I am not required to sign this Authorization and that AAIA may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA.

This authorization will expire after one year or sooner if revoked in writing.

(Check One) I DO ____ DO NOT ____ Give Permission to AAIA to leave information on my answering machine and/or with my family members in regard to treatment plans, referrals, test results and/or billing and payment information. HIPAA guidelines allow for basic information regarding appointment (time, date, location) to be left on an answering machine or with family members.

HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from third party payers, and the day-to-day healthcare of operations of AAIA., Other than those released authorized by HIPAA, PHI will only be released to persons listed on this authorization. If you choose not to authorize any family members or friends for disclosure of PHI, AAIA will not be able to release any information, including appointment of patient billing questions to anyone other than the patient.

Signature of Patient or Personal Representative

Relationship of Personal Representative to Patient

Date of Authorization _____



FINANCIAL MATTERS

Allergy, Asthma & Immunology Associates, P.C. of Omaha and Lincoln, is extremely pleased to provide care to you and your family. The following details outline our clinic's financial policy:

We must emphasize that as a medical practice, our relationship is between you and our physicians, not the insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, it is often necessary for you to inquire and explore your benefits with your insurance carrier. The patient is responsible for any portion of the charges deemed non-covered or noted as "Patient Responsibility".

AAIA is a private practice (independent) clinic. AAIA is not directly affiliated with outside laboratories, clinics, pharmacies, or physicians; when AAIA physicians write lab orders, our physicians are not liable for the charges, fees, and bills you may receive when you have services or labs drawn through these non-AAIA entities. AAIA emphasizes that new and established patients must: a) check with their specific insurance plan to determine which of AAIA's physicians and locations are "in-network" for their benefits; b) check in advance with their insurance plans to determine coverage and exclusions; c) check in advance with laboratories, non-AAIA physicians, and pharmacies, to understand the services, charges, and patient financial responsibilities that they will have with the non-AAIA entities.

The patient is required to present an insurance card(s) at each visit. Failure to provide this information may result as a "self pay" patient. If you have no insurance coverage or your charges are subject to a large yearly deductible, a minimum down payment of \$200.00 towards the balance is expected at the time of your visit if you are a NEW patient. A minimum down payment of \$100.00 towards the balance is expected at the time of your visit if you are an ESTABLISHED patient. Our fees are subject change. Per the No Surprises Act of 2022, if you would like a Good Faith Estimate of the costs for services/procedures anticipated to be rendered, please contact our Business Office. Additionally, our Business Office will contact you to establish a formal payment plan for the remaining balance.

Our office files all insurance claims, however, we may not be participating providers for all insurance plans. **It is your responsibility to check with your insurance payer before your visit to see if AAIA is in network with your plan. Services listed as "covered" by your plan, are still subject to the patient financial liability for their deductibles, co-insurance, and co-payments (as outlined in your plan).**

Note that when referring to your plan benefits and coverage, the physicians, and mid-levels (physician assistants, nurse practitioners) at our clinic, are categorized as specialists.

All co-payments are due at the time of service, including injection patients who have a co-payment/co-insurance payments associated with each administration injection.

If your insurance provider requires a referral, such as Tricare Prime members, **you** are responsible for getting a referral to our office from your primary care (PCP) doctor. This must be done no later than **48 hours** prior to your appointment. We follow guidelines set forth in those plans and services cannot be rendered if proper authorization has not been given. Please have your referring doctor fax the referral to (402) 464-3650 or call (402) 464-5969.

Once the insurance company has processed the claim, you will receive a billing statement which shows the patient responsibility portion of your services.

- Payment in full is expected when you receive your statement. Checks or credit card payments may be mailed to PO Box 82596, Lincoln, NE 68501. Payments in cash or by check are accepted in person at all locations.
- Payments by credit card (Visa®/MasterCard®/Discover®/American Express®) are accepted in person or over the phone by calling our Billing Office at 402-417-7477.
- If you are unable to pay your balance in full at the time you receive your statement, please call and speak with one of our billing staff to set up a monthly payment plan.
- A \$50 Service Fee will be added to all checks returned for insufficient funds. If your check is returned, you will be required to pay cash, money order, or credit card for the services.

Our entire staff is committed to giving all our patients the best service and care. Due to the high demand for appointments, Allergy, Asthma and Immunology Associates, P.C., has a "no show policy". **Our office may charge a \$25 fee for no-shows and cancellations with less than 24 hours notice.** This fee may be subject to change without notification. Exceptions may be made for extenuating circumstances. The payment of this fee is the responsibility of the patient, not of the insurance company. Please make note of your appointment date. As a courtesy, our staff will attempt to confirm your appointment two (2) or more days in advance. Please keep all contact information current. In the event that we are unable to reach you, it is still your responsibility to keep your appointment.

I understand and agree to the terms of this Financial Policy:

Signature of Patient/Responsible Party

Date:

Print Patient Name/Responsible Party