Allergy & Asthma Center, P.C.

Eastpointe at Marlboro
15 South Main Street
Marlboro, NJ 07746
Tel (732) 303-8787

Freehold Office
1001 West Main St., Suite A
Freehold, NJ 07728
Tel (732) 780-7807

Bethany Commons
1 Bethany Road
Hazlet, NJ 07730
Tel (732) 739-8787

Financial Policy

We are committed to providing you with the best possible care are willing to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR.

WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- COPAYMENTS – By law we MUST collect your carrier designated copay at the time of service. Please be prepared to pay that copay at each visit.

- NON CO-PAY PLANS – If your plan does not require a copay and we participate, we will accept the designated fee. You are responsible for any deductible and balance your plan indicates on their explanation of benefits.

- REFERRALS – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, you will be required to sign a financial waiver and pay for your visit. It is then your responsibility to provide us with the referral a soon as possible.

- NON PLAN PATIENTS – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Your itemized receipt should be attached to your insurance form and sent to your carrier (if applicable).

- MEDICARE – We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

PATIENT RESPONSIBILITY: I realize that I am responsible for my copay plus any deductible or amount indicated on my explanation of benefits as patient responsibility. I am aware that interest of 1.5% per month is accrued on overdue balances, not to exceed 18% total for the year. I am aware that there is a $25 fee for all returned checks. If my account is sent to collection, I realize that I am responsible for the collection fees and reasonable attorneys fees as allowed by law.

THANK YOU for taking the time to review our policies.

RESPONSIBLE PARTY SIGNATURE_____ DATE_____