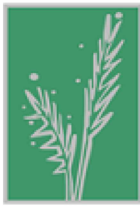

Southtowns Asthma & Allergy Center
Luis Melgar, Physician PC
5893 Camp Road, Suite 3
Hamburg, NY 14075
P: (716) 648-7401
F: (716) 648-7421

Luis Melgar, MD

Internal Medicine – Asthma – Allergy – Immunology – Botox – Dermal Fillers

FINANCIAL POLICY

Medicare/PPO/HMO/Managed Care: You are responsible for remitting co-pays at the time of service and unless otherwise indicated, responsible for obtaining the necessary referrals/authorizations your plan requires. If you fail to do so, you will be responsible for payment. These are policy provisions which you agreed to adhere to when you signed up for the plan. We will submit all charges and follow-up with your carrier for payment. You are responsible for all deductibles, co-pays and any other non-covered charges. **Any high deductible HMO plan will requires a $79.00 deposit towards charges incurred. It will be applied to the annual deductible charged by you insurance carrier. This is considered an "estimated" fee. You will be billed any outstanding balance after insurance processing.**

No-Fault/Workers Compensation: You are responsible for providing our office with the necessary information needed to properly submit charges. If you fail to do so, the fees mandated by NY State will be changed to reflect our private fees and you will be responsible for payment. Some No-fault carriers have deductibles on medical charges, for which the **patient** (not the insured) is responsible. If you have private insurance we will submit on your behalf and bill you for any unpaid balances.

Medicaid: You are responsible for providing our office with your ID# (begins with 2 alpha letters, followed by numerical digits & ending with 1 alpha letter). If you have a managed medicaid plan (Fidelis Care, Total Care, etc) you are responsible for obtaining a referral from your Primary Care Physician; otherwise payment will not be made. If you fail to do so, you will be responsible for payment.

Non-participating Carriers: You are ultimately responsible for all charges if we do not have a participation agreement with your insurance carrier. If you provide our office with the necessary information needed to properly bill, we will submit on your behalf. You are responsible for following-up with your insurance carrier for unpaid claims and/or appeals. You are responsible for all deductibles, co-pays, and non-covered charges.

Liability: Carriers usually remit payment to the patient or the patient's attorney if one has been retained. OUR POLICY DOES NOT ALLOW US TO HOLD ACCOUNTS WHICH ARE PENDING RESOLUTION OF ANY LIABILITY OR LITIGATION ISSUES. **WE DO NOT, UNDER ANY CIRCUMSTANCE, BILL ATTORNEYS.** If you provide a letter from the liability carrier indicating they accept full responsibility and will remit payment, we will submit on your behalf. Otherwise, you may either have charges submitted to your private carrier or pay for services and obtain reimbursement upon resolution/settlement.

Self-pay: If you are uninsured, you are responsible for remitting payment in full at the time of service, unless prior arrangements have been made with the Billing Department. If you are unable to remit payment in full and need to discuss payment options available to you, you must contact our Billing Department at 648-7401**. The standard & self pay rate is $85.00 per office visit. However, this is subject to fluctuate with services rendered.**

No Show Policy: If you fail to cancel a scheduled appointment 24-48 hours prior to your scheduled appointment, or fail to show up for a scheduled appointment, **a fee of $76.00** will be billed to you. Repeated "No Shows" may result in dismissal from the practice.

Form Fee: Forms needing to be filled out for you by our office that are not brought in at an appointment will be subject to a $25 administrative fee per form. This charge is not covered or billed to your insurance. Payment is due when the form is dropped off at our office.

Payment: Payments for co-pays and account balances made at the window must be paid in Cash, Master Card, Visa or Discover Card. **NO CHECKS WILL BE ACCEPTED AT THE WINDOW.** If a check, for account balances, mailed into our billing department and does not clear, **a fee of $30** will be charged to your account.

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare Benefits be made on my behalf to provider for any services rendered to me by the physician. I authorize any holder of medical information about me to be release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

If you need further explanation of any of the above policies, please contact the Billing Department directly. Thank you for your cooperation in this matter.
I have read and/or been advised to read the entire Financial Policy.

Date: Signature: