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Chico, California 95926
T 530.896.2200
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PATIENT FINANCIAL RESPONSIBILITIES

Fees for Service

We will bill your health insurance company for the services you receive, using the insurance information you provide at the time of service. You are responsible for the balance of charges after insurance claims have been processed. This can include deductible, co-payment, co-insurance and charges for services not covered by your health plan. Your signature, below, constitutes your agreement to pay for services pursuant to insurance billing, whether or not services are covered by your policy.

Please be prepared to pay your copay and a portion of your deductible at the time of service.

***Upon request, we will provide you with a cost estimate prior to services being rendered.

We ask that parent(s) or legal guardian(s) be present with all patients under the age of 18.

Unfortunately, we are not currently accepting any Managed Care or Medi-Cal, as either Primary or Secondary carrier.

Missed Appointments

A fee of $100 will be charged for new patient appointments that are missed or cancelled without a minimum of 24 hours notification. An established or current patient will be charged a $25.00 fee, as established by Allergy Associates for failure to show to the appointment.

Any patient who has been a “no show” more than three times will be reviewed for dismissal from the Practice.

Payment Arrangements

Payments may be made in cash, by check or credit card (Visa or Mastercard). All returned checks are subject to a **$35.00 service fee per check**.

Collections

Outstanding balances that remain unpaid after 90 days of the invoice due date may be referred to a third-party collection agency. The holder of this medical debt contract is prohibited by section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void an unenforceable.

We are happy to discuss with you any questions relating to the information above. We thank you for choosing Allergy Associates of Northern California for your allergy services. We are proud to be your physicians.

Patient Name _____ Guardian Name _____

Patient Signature _____ Guardian Signature _____

Date _____