Office and Financial Policies Statement

Thank you for choosing Allergy, Asthma & Food Allergy Centers of St. Louis as your healthcare provider. The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read, initial and sign this form. Feel free to ask if you have any questions regarding your financial responsibility. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this policy with them, as it explains our practices regarding insurance billing, copayments, and patient billing.

Allergy, Asthma & Food Allergy Centers of St. Louis is contracted with most major commercial insurance companies, Home State Health, AmBetter, and Medicare. Please contact your insurance provider prior to treatment to verify coverage. Non-covered services are the patient's responsibility and due at time of service.

Due to frequent changes in health insurance coverage, we require you to provide proof of insurance coverage at every visit. If you do not have insurance, are unable to provide proof of insurance coverage, or participate in a plan our office does not accept, payment in full will be required at time of service.

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Please be aware that some services provided may be considered non-covered services and not reimbursable by your insurance company. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, coinsurance amounts, or any other patient responsibility indicated by your insurance carrier, which are not otherwise covered by supplemental insurance. All co-payments are due at time of service. These fees cannot be waived, per our contract with your insurance company.

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We submit claims to primary, as well as secondary insurances, if applicable, for each visit. All insurance payments are paid directly to Allergy, Asthma & Food Allergy Centers of St. Louis for services rendered. You will be mailed a billing statement that contains the total cost of your service(s) or procedure(s) received during your visit(s). You may generally expect this billing statement within twenty (20) days after your insurance company has responded to a submitted claim.

You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at Allergy, Asthma & Food Allergy Centers of St. Louis and you have not obtained such an authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at our office are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services; or (v) you have chosen not to use your

health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly. Please note that any benefit information received from our office is an estimation, not a guarantee. Benefits are not determined by your insurance company until your claim has been received for processing.

By my signing, I understand and acknowledge that my health insurance provider may not pay Allergy, Asthma & Food Allergy Centers of St. Louis for all of the charges in connection with the medical services rendered. Therefore, I authorize Allergy, Asthma & Food Allergy Centers of St. Louis to charge my credit card listed on the "Credit Card Pre-Authorization Form" for any balance my insurance company deems patient responsibility. I understand that the card on file will be utilized in the case that my account becomes 45 days past due. I also understand that it is my responsibility to plan so that such charge will not exceed my maximum allowable credit limit. If the credit card payment is declined and Allergy, Asthma & Food Allergy Centers of St. Louis is unable to obtain payment, there will be an additional fee of $50.00.

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In the event an outstanding balance becomes a hardship, I understand that I have the opportunity to contact Allergy, Asthma & Food Allergy Centers of St. Louis to schedule a formal monthly payment plan.

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If any balance on your account is over ninety (90) days past due and no contact has been made to the office, your account will be in default and referred to a collection agency and will result in dismissal from our practice.

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Adolescent patients not accompanied by a parent are responsible for copayment or any charges pre-determined not covered by insurance at the time of service.

In divorce or separation cases, the parent with whom the child resides will be listed as guarantor of the account and therefore is responsible for any balance incurred. If a divorce decree requires the non-custodial parent to pay all or part of medical expenses, it is the custodial parent's responsibility to seek reimbursement from the non-custodial parent.

We will make every effort to accommodate your scheduling needs. In return we ask that you help us by keeping your scheduled appointments and notifying our office at least 24 hours in advance if you are unable to keep your appointment.

First and second appointments not cancelled with 24 hours prior notice will result in a $50.00 fee. (New patients, Food challenges and Day 1 – New Starts for OIT will be charged a $150.00 fee). Third appointment not cancelled with 24-hour prior notice will result in a $50.00 fee and may result in dismissal from our practice.

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By signing below, the undersigned acknowledges that: (i) I have been presented a copy of the Allergy, Asthma & Food Allergy Centers of St. Louis Office and Financial Policies Statement; (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) and I agree to the assignment of benefits from my insurance company to Allergy, Asthma & Food Allergy Centers of St. Louis.

ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

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Patient/Responsibility Party/Guardian Date