ARCADIA Allergy & Asthma
SAN TAN Allergy & Asthma

Sam Reed Shimamoto, MD ● Jennifer Hill, MD ● Priscilla Wong, MD
4915 E Baseline Rd #112 Gilbert, Arizona 85234
4840 E. Indian School Rd. #101 Phoenix, Arizona 85018
Phone (480)526-7788 OR (480)626-6600 -- Fax (480) 626-6604

S. Reed Shimamoto, MD • Jennifer Hill, MD • Priscilla Wong, MD

OFFICE FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. A copy of your current insurance card and verification of your address is required at **every visit**. You are responsible for ensuring your address and insurance on file are correct. You are responsible for any unpaid balances or fees that arise if this information is not updated.

2. As outlined by your insurance plan, you are responsible for all co-payments, deductibles, and coinsurances. Payment of co-pays and deductibles is due at time of service based on benefit information provided to us by your insurance company. If you are unable to pay your balance due at time of service, you will be asked to reschedule. **INITIALS** _____

3. We will submit to your secondary insurance, as a courtesy to you. If the secondary does not cover the balance owed from the primary insurance, you are responsible for any balance on the account. **If you have AHCCCS as your secondary, please be aware that you will be expected to pay for any services AHCCCS does not cover. For example, if you are over the age of 21, you are financially responsible for these services: Allergy injections, serum, skin testing, and patch testing. INITALS**_____

4. It is your responsibility to understand your insurance benefit plan, and to know if a written referral or authorization is required to see specialists. Often a pre-authorization is required prior to procedures. **We strongly urge** you to contact your insurance company prior to your appointment for detailed benefit coverage, policy limitations, and non-covered services.

5. If our physicians do not participate in your insurance plan, payment in full for your visit is due at the time of your visit. _____**INITIALS**

6. If you don't have insurance, payment in full for your office visit is due at the time of the visit. **INITIALS**_____

7. Missed appointments not only impact you, but other patients wanting to be seen. If you are unable to keep your appointment, we require 24-hour advance notice to cancel so we can open this time up for other patients to schedule. If you do not call within the 24-hours, you are subject to a $50.00 fee for established patients; New Patients, your missed appointment will be subject to a $100.00 fee. **INITIALS** _____

8. If payment arrangements have not been made with our billing department prior, patients with outstanding balances over 60 days will not be scheduled for appointments and will not be provided refills until balance is paid in full or payment plan has been set up with our billing department. **INITIALS** _____

9. If payment arrangements have not been made with our billing department prior, **any balance over 90 days is subject to being assigned to our collection agency and discharge from the practice**. Furthermore, additional fees up to 35% of the outstanding balance, collection agency charges, attorney's fees, and any other costs will be applied to all balances placed with our collection agency. **INITIALS** _____

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10. A $25.00 fee will be charged for any checks returned, along with any bank fees incurred. **INITIALS** _____

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11. If you are requesting a copy of Medical Records, there will be a $25 fee per chart. There is no fee if the records need to be sent to another medical provider. _____ **INITIALS** _____

12. Should you have forms that need to be completed and signed by the Physician or staff you may be subject to a $30 fee**.**_____**INITIALS**

13. In the event that your provider has requested for a eNO (enhaled nitric oxide) test to be performed, as a courtesy I understand it will be billed to my insurance first, and if it is not covered I will be responsible for $26.00**. INITIALS** ___

I have read and understand **San Tan Allergy & Asthma's** Financial Policy and agree to comply and accept responsibility for any payment that becomes due as outlined previously.

Patient Name(s)
_____DOB_____

Responsible party member's name_____
DOB_____

Responsible party member's signature_____ Date_____