Wolff Allergy & Asthma
Fisher Building
3011 West Grand Boulevard, Suite 210
Detroit, MI 48202
Office: (313)-871-7572
Fax: (313)-871-7573

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing ***Wolff Allergy & Asthma*** as your healthcare provider. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service.

- The patient must store a credit card on file. The credit card information will be held securely. A claim for every office visit will be sent to patient's insurance company. If a portion of the bill applies to the patient's responsibility, the credit card will be used to secure that portion. Charges that do not successfully process or are denied through credit card on file or at time of appointment will remain patient's financial responsibility. Any charge that has not been paid within 30 days from the last visit, will incur a late charge of $35.00. Any account that has not been paid 60 days from the explanation of benefits, will be sent to collections. We will not be able to reverse any accounts that have been sent to collections.

- The patient is responsible for no show and cancellation fees.

- If patient cancels an appointment less than 24 hours prior to the scheduled appointment, a charge of $25.00 will be made to credit card on file. This $25.00 charge can be reimbursed if patient completes appointment at another date and time. If patient cancels the rescheduled appointment, another $25.00 fee will be charged to credit card on file.

- If patient is a no show at an appointment, a $25.00 charge will be made to the credit card on file and this is non-refundable. Please note the $25 cancellation fee cannot be submitted to insurance and is the sole responsibility of the patient. Please make every effort to attend your scheduled visit.

Patient Authorizations

- By my signature below, I hereby authorize WolffAllergyAsthma, PLLC to release medical and other information acquired in the course of my examination and/or treatment (with the exceptions stipulated below) to the necessary insurance companies and third party payers.

- By my signature below, I agree to leave a credit card on file for billing purposes.

- By my signature below, I hereby authorize assignment of financial benefits directly to WolffAllergyAsthma, PLLC and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

____ Date: _____________

Printed Name of Patient (or parent/guardian if patient <18 years)

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Signature of Patient (or parent/guardian if patient <18 years)