Allergy and Asthma Center of Montana, PC

401 15th Ave S. Suite 104 Great Falls, MT 59405
Phone (406) 771-9050 Fax (406) 761-1090

PAYMENT POLICY

1. **Billing Insurance:** It will be our pleasure to bill your insurance company for you, provided that you submit accurate billing information.

2. **Co-Pays:** Co-Pays are expected at the time of services, no exceptions. It is your contractual agreement with your insurance to pay your co-pay at the time of service.

3. **Coverage Changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you with the payment expected within 30 days.

4. **Nonpayment:** If your account is over 60 days past due, we will expect payment in full before further treatment is provided by our facility. Understand that you will be charged a late fee of $10.00 a month for accounts that are past due. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and your child and your immediate family members may be discharged from this practice.

5. **Missed Appointments:** Please notify us of a canceled appointment at least 24 hours prior to your appointment time. Our policy is to charge up to $100.00 fee for missed appointments or appointments canceled without 24 hour notice. These charges will be your responsibilities and billed directly to you.

6. **Payments:** If you are currently without insurance coverage, we offer a discount for payment in full at the time of service. We accept payments by cash, check, or credit card.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY FOR ALL CHARGES, REGARDLESS OF INSURANCE OR OTHER THIRD PARTY COVERAGE.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINES:

_____ **DATE:** _____
Signature of Parent/Legal Guardian

_____ **DATE:** _____
Printed Name of Parent/Legal Guardian