NORTHWEST ASTHMA & ALLERGY CENTER (NAAC)
NOTICE OF PRIVACY PRACTICES & FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT (Effective 12/1/17)

NOTICE OF PRIVACY PRACTICES

Northwest Asthma & Allergy Center (NAAC) has a responsibility to protect the privacy of your health care information. We maintain a record of the healthcare services we provide you. We will share this information, as permitted by law, to provide and coordinate your medical treatment, bill for these services, and conduct usual health care operations. You have the right to review, obtain a copy, or request to amend the record if needed.

Our ***Notice of Privacy Practices*** describes in more detail your rights to your health information and how this information may be used and disclosed. Sharing of your health information is typically used to improve the continuity of care that you receive. Common examples include accessing prescription history for pharmacy benefits, discussing an opportunity to enroll you in clinical research studies with our non-profit research affiliate, ASTHMA, Inc. and/or participating with Health Information Exchanges (HIE) with other health care organizations to improve quality, safety and efficiency of health care. We may change the Notice of Privacy Practices at any time; a current copy is found on our website: www.nwasthma.com or you may contact our Privacy Officer for additional questions or concerns.

FINANCIAL POLICY

1. ***Payment for all medical care is the patient's responsibility regardless of insurance coverage.***

2. Patient Information/Proof of Insurance: At each visit, please be prepared to present your insurance card as proof of insurance.

3. Insurance: We participate in most insurance plans and will submit claims on your behalf to the insurance company. **Knowing your insurance benefits and rules is your responsibility**. We highly encourage you to call to verify your own benefits along with any limitations you may have on your policy. If your plan has limitations, it is your responsibility to share these limitations with the provider prior to having any procedures performed. If your insurance company requires a specialist referral from your primary care physician, it is your responsibility to obtain that referral prior to scheduling your appointment. Referrals (including allergy shots, biologic treatments, and procedures) must be up-to-date and on file prior to all appointments. You will be responsible for any charges resulting from an out-of-date referral.

4. Co-payments and deductibles: **Co-pays must be paid at the time of service**. Parent or adults accompanying a minor will be responsible for the patient's co-pay and bill at that visit.

   If insurance discloses that there is an unfulfilled deductible over $300 for a new patient or over $150 for an established patient, you may be required to make a minimum down payment of $300 at the initial visit or $150 at the established visit. The remaining balance will be due at the time of receipt of your invoice (billing statement).

5. Non-covered services: Our providers follow appropriate medical guidelines for standards of care based on your medical condition. Please be aware that some of the services you receive may be determined by your insurance plan to be only partially covered or not covered. **You will be responsible for the cost of services that is not paid by insurance.**

6. Claims submission: We will bill your insurance company on your behalf. You are responsible to know your own insurance benefits. Coverage, co-payments, co-insurance and deductibles can change on an annual basis. If there is a change in your insurance coverage, please notify the clinic as soon as possible. Some insurance companies have time limits on when claims need to be submitted. If we do not have the correct information, we cannot file the claim in a timely manner.

7. Account balances: All account balances are due upon receipt of your billing statement. If the account remains unpaid after 90 days, it will be referred to a third party collector. Failure to pay the account balance may result in discharge from the practice, including family members who are also patients. In such case, you may request that your medical records be transferred to another provider at no charge. If, after being discharged, you would like to be considered for reinstatement to the practice, all financial obligations must be paid in full. Reinstated patients are required to maintain a credit card on file.

8. Method of Payment: We accept cash, checks, and credit cards including: American Express, Discover, MasterCard or Visa.

9. Returned checks: Any non-sufficient fund checks will be charged a $35 fee.

10. Credit Card On File: We encourage patients to keep a credit card on file to make the checkout process easier, faster, and more efficient. After your insurance has paid its portion of your bill, we will notify you via e-statement of the balance owed, charge your credit card the balance owed 31 days after you receive your e-statement, and send a receipt for the charged amount. Credit card numbers are encrypted and stored securely off-site. No credit card numbers are stored at our practice. All Private Pay patients are required to have a credit card on file or they will not be scheduled or seen for an appointment.

11. Telephone service: If you request medical services via telephone instead of a visit to our office including after hours, you may incur telephone service fees. This will be billed to your insurance company but may not be a covered service. You must be an established patient to request this service. If the phone visit is pertaining to an office visit within the previous 7 days or results in an office visit within 24 hours or next available urgent visit, you will not be charged for telephone service.

12. Late cancel and no-show appointments: **If you arrive late (≥15 minutes) for your appointment, you may be asked to reschedule to another day. Late cancel (≤ 24-hours notice) and no-show appointments incur a $75 fee; for vocal cord dysfunction appointments, the fee is $150.** New patients will need to complete and sign our Financial Policy and Credit Card on File (CCOF) forms prior to scheduling another new patient appointment. If a patient late cancels or no shows twice within a 12-month period, s/he and other family members will be discharged from the practice. When you make an appointment, **it is your responsibility to attend the appointment or give us 24-hours notice**. **A reminder is a courtesy.**

13. Divorce/Separation: In cases of divorce and/or separation, the legal guardian and/or the person completing paperwork and/or bringing the child in for the **initial** visit will be considered the Guarantor and will be held responsible for paying any medical services. If you provide legal documentation that someone other than the legal guardian is financially responsible and you provide billing information for that responsible party, we will attempt to bill that party. However, if the balance is unpaid by that person, you will be held responsible for the balance on your child's account.

I have reviewed a copy of the Notice of Privacy Practices which provides information about how my health information may be used and disclosed. I have read and understand the Financial Policy of Northwest Asthma & Allergy Center (NAAC). I assign payment from my insurance directly to NAAC. I understand that I am financially responsible to NAAC for the charges not paid by insurance and that those charges are due upon receipt of invoice (billing statement).

I consent to the plan of care proposed by the providers in this clinic. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care and will make my wishes known. I understand that NAAC participates in the training of physicians and other healthcare providers and consent to their involvement. I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis or test performed at or by NAAC.

Patient/Guarantor Signature	Date	
Printed Name of Signature Above	Relationship to Patient	
Patient's Name	Date of Birth	Acct # (office use)
Patient's Name	Date of Birth	Acct # (office use)
Patient's Name	Date of Birth	Acct # (office use)
Patient's Name	Date of Birth	Acct # (office use)