NORTHWEST ASTHMA & ALLERGY CENTER (NAAC)
NOTICE OF PRIVACY PRACTICES & FINANCIAL RESPONSIBILITY
ACKNOWLEDGMENT

NOTICE OF PRIVACY PRACTICES

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

Our ***Notice of Privacy Practices*** describes your rights to your health information and how this information may be used and disclosed. Sharing your health information is typically used to improve the continuity of care 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. dba Seattle Allergy & Asthma Research Institute, and/or participating with Health Information Exchanges (HIE) with other healthcare 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 of services: The cost of all medical care is the patient's responsibility regardless of insurance coverage.

2. Patient information/proof of insurance: If the patient is insured, we require that it be disclosed to us for billing purposes and that the insurance ID card is presented for proof of insurance. The patient is responsible for updating us promptly if there is a change to the insurance plan.

3. Insurance: We participate in most insurance plans and will submit claims on your behalf to your insurance company. Knowing your insurance benefits and rules is your responsibility. We highly encourage you to call to verify your benefits and any limitations on your policy. If your plan has limitations, you are responsible for sharing them with the provider before any procedures are performed. If your insurance company requires a specialist referral from your primary care physician and/or approved by your insurance plan, it is your responsibility to obtain that referral before scheduling your appointment. Referrals (including allergy shots, biologic treatments, and procedures) must be up-to-date and on file before all appointments. You will be responsible for any charges resulting from an expired referral.

4. Co-payments: Co-pays must be paid at the time of service.

5. Private pay: If you do not have insurance, a $300 deposit will be required for a New Patient visit; a $150 deposit will be required for an Established Patient visit. If any amount remains after charges are covered, it will be applied to future visits. Most services will receive a 20% discount.

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

7. Claims submission: We will bill your insurance company on your behalf. You are responsible for knowing your insurance benefits. Coverage, co-payments, co-insurance, and deductibles can change annually. Some insurance companies have time limits on when claims must be submitted. We cannot file the claim promptly if we do not have the correct information.

8. Account balances: All account balances are due upon receipt of your billing statement. The account may be referred to a third-party collector if it becomes past due. Continued failure to pay the account balance may result

in discharge from the practice, including family members who are also patients. In such a case, you may request that your medical records be transferred to another provider at no charge. If you are discharged, you may be reinstatement to the practice only after all financial obligations have been paid in full.

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

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

11. Late cancel and no-show appointments: If you arrive more than 15 minutes after your scheduled appointment, we may ask you to reschedule for another day, which will be a no-show appointment. Most late-cancel (less than 24- hour notice) and no-show appointments will incur a $75 fee. If a patient late-cancels or no-shows twice within 12 months, the patient and other family members on the account may be discharged from the practice. While we send out courtesy electronic reminder notices, the patient must attend the appointment or give us 24-hour notice for canceling or rescheduling.

12. 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 for any medical services. If you provide legal documentation that someone other than the legal guardian is financially responsible and provide billing information for that accountable 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 the 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 care plan. 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 training physicians and other healthcare providers and consents 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)