



YUILL BLACK, M.D. AND MICHAEL R. KLETZ, M.D., P.C.

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APPAJI GONDI, M.D.
DIPLOMATES AMERICAN BOARD OF ALLERGY & IMMUNOLOGY**

PATIENT RESPONSIBILITY AGREEMENT

By signing this form you are agreeing to the following office financial policies.

- An insurance card must be provided for each doctor visit, before seeing the doctor, regardless of when you were last seen.
- All deductibles, co- insurance, and/or co-payments are due at the time of service.
- If there is an outstanding account balance, it must be paid before being seen by the doctor or before serum production.
- If an appointment is cancelled or rescheduled with less than 24 hours' notice, or the patient fails to show for a scheduled appointment, a \$30 fee will be applied to the account. The fee for a venom or penicillin testing appointment is \$50.
- There is a \$10 charge for each school or work form that needs to be filled out by the doctor.
- There is a \$35 fee for any returned check to our office.
- The provider reserves the right to add a \$10 monthly processing fee to any account that has an unpaid personal balance resulting in more than one statement notice.
- Unless payment arrangements have been made, any outstanding personal balance not paid after 90 days of notice for payment will be referred to an outside agency for collection. A 25% collection fee will be added to the total balance owed.

PATIENT CONSENT

I understand that providing proof of my insurance plan(s) or explanation of benefits does not hold Black & Kletz, MD, PC. responsible for verifying this information. I accept financial responsibility for any lapse on my part in providing a referral, if necessary, and/or understanding my insurance benefits at the time services are rendered. I understand it is my responsibility to notify the office of any changes to my insurance information (including new prefix to ID #, new group #, claim submission address), or personal address or phone information.

I will cooperate with the billing department of Black & Kletz, MD, PC. to ensure payment for my services. I understand that I will be responsible for any cost(s) associated with the collection of my account if I default on this agreement. I understand that the terms of this financial policy may be amended at any time without prior notification to me, the patient. In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for payment for all services rendered to the patient herein.

Printed name of Patient/Parent/Guardian

Signature of Patient/Parent/Guardian

Date

Account #

Staff ID