D. L. Southern, M.D. J. Caucino, D.O. H. Skolnick, M.D.
K. Sikorski, M.D. S. Shah, M.D

Princeton 609-921-2202 Plainsboro 609-799-8111 Hamilton 609-888-1555
Flemington 908-782-0093 Fax #: 609-924-1468

Payment Policy

Thank you for choosing us as your provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are insured by a plan we are not contracted with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with questions you have regarding your coverage.

2. **Responsibility for Medical Care.** Every minor child, under the age of 18, seen in our office for medical services must be accompanied by a parent or legal guardian, or by an adult who has obtained written consent for treatment from the parent or legal guardian. The accompanying parent of a minor will be responsible for copayments, co-insurance, deductibles, & non-covered services. In the case (such as divorce) it will be up to him/her to seek repayment from the other parent. Our top priority is to treat your child's medical needs, not be placed in the middle of your dispute.

3. **Copayments.** All copayments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments can be considered fraud. Please help us in upholding the law by paying your copayment at each visit. We do not accept cash payments.

4. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services at time of service or with-in **14** days of billing statement.

5. **Allergy Injection patients.** Your serum has different concentrations with different expiration dates. If you are noncompliant with your injection schedule and your serum has expired, we will have to re-dilute your serum. The cost of re-diluting serum has markedly increased. Princeton Allergy and Asthma will absorb the expense of re-dilution one time only. Going forward the cost of $50 will be the patient's responsibility.

6. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of a current valid insurance card to provide proof of insurance. If you fail to provide the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

7. **Claim submission.** We will submit your claims and assist you in any way we reasonably can to get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If they have not paid within **60** days, the balance will be billed to you. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

8. **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.

9. **Nonpayment.** If your account is over **30** days past due, you will receive a letter stating that you have **14** days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid past **45** days, we may charge a service fee of $30 and refer your account to IC SYSTEM, a National Collection Agency authorized to credit report all debts to the four major National Credit Agencies and litigate in a court of law. Where any part of your medical account with PAAA has fallen into arrears, then the totality of that account shall become immediately due and payable.

10. **Additional cost of collection services.** Invoices shall be deemed to be accepted by you unless PAAA is notified in writing within **14** days of the invoice that you dispute it. In the event of delinquent accounts, PAAA will charge a service fee. In addition, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

IT IS THE RESPONSIBILITY OF THE PATIENT TO NOTIFY OUR OFFICE OF ANY INSURANCE AND/OR DEMOGRAPHIC CHANGES.

PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED.
A FEE OF $35.00 WILL BE CHARGED FOR ALL RETURNED CHECKS.

Payment Policy is subject to change without notice.

I have read and understand the payment policy and agree to abide by its guidelines.

Print Patient Name ____

Signature of patient or responsible party ____ **Date**___________

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Office Policy

All Patients

- All patients under 18 years of age must be accompanied by their parent or guardian.
- If you have labwork done and would like a copy of the results, we ask that you obtain them from the lab. We will provide information for retrieving them from the lab website. There may be a charge to have us copy them for you.
- Patients receiving allergy injections **must** wait 30 minutes before leaving our facility.

Patients with HMO or POS Plans:

- A valid referral must be presented at the time of your appointment; patients are responsible for payment in full if the proper paperwork is not on file.
- Our office must have a valid referral on file prior to preparing allergy serum for patients.
- It is the patient's responsibility to keep track of authorized visits to our office.

Allergy & Patch testing:

- Allergen skin testing and patch testing are routine procedures done in our office. These aid in the diagnosis and management of your condition.
- The risks of these tests are very minor and may include local redness/rash and swelling at the site. Rarely, anaphylaxis can occur related to allergen skin testing. In the event of a reaction, you may receive treatment with any of the following medications including Benadryl (oral or topical), steroids (oral or topical) and in rare cases, epinephrine.

Allergy Injection Patients

- Your serum has different concentrations with different expiration dates. If you are noncompliant with your injection schedule and your serum has expired, we will have to re-dilute your serum. The cost of re-diluting serum has markedly increased. Princeton Allergy and Asthma will absorb the expense of re-dilution one time only. Going forward the cost of $50 will be the patient's responsibility.

Prescription refills

- **BEFORE CALLING OUR OFFICE FOR A REFILL, PLEASE CHECK WITH YOUR PHARMACY to find out if any refills are present.** If no refills are present please have your pharmacy contact us. You may also request a refill through the patient portal on our website. We do require 72 hours notice if a prescription is needed.
- For proper medical care, patients must be seen within 6 months to obtain a refill.
- If your insurance company requests a 3 months mail-in order, please allow ample time for the order to be received through the mail. The patient is responsible to mail in the prescription.

Medical Records and Forms

- School or Camp Forms: must be filled out with the patient's information by the parent. There is a $15 fee and we require 7-10 business days for all forms to be completed.
- Written authorization from the patient/parent or guardian must be obtained to release medical records.
- Two weeks' notice is required to complete your request for medical records and/or the completion of school or camp forms.
- **A $15.00 processing fee applies to the above requests and any records over 10 pages will be charged $1.00 per page.**

No Show and Cancellation Fee

- A 48-hour cancellation notice is required for all appointments. **A fee may be implemented if required notice is not given or if you fail to show for your appointment.**

Office Policy is subject to change without notice.

I have read and understand the office policy and agree to abide by its guidelines.

Print Patient Name ____

Signature of patient or responsible party ______________________________ **Date**__________

9/12/23 **Please sign both sides. Over →**