BERKS SCHUYLKILL RESPIRATORY SPECIALISTS AND THE SLEEP HEALTH CENTER
2608 Keiser Blvd, Wyomissing, PA 19610
Tel: 610-685-5864 Fax: 610-929-1528
BERKSHIRE ASTHMA AND ALLERGY CENTER
2210 Ridgewood Rd., Suite 100, Wyomissing, Pa.
Tel: 610-372-0502 Fax:610-372-9554

Financial Policy

Thank you for choosing Berks Schuylkill Respiratory Specialists/The Sleep Health Center. The following is a statement of our FINANCIAL POLICY. All patients must accept our FINANCIAL POLICY before receiving treatment.

METHOD OF PAYMENT
We accept CASH, CHECK, VISA, MASTERCARD and DEBIT CARDS. Payment plans may be arranged on an individual basis with our billing department.

REGARDING YOUR INSURANCE
As a courtesy to you, we will submit medical claims to your insurance company. Any balance after processing of our claim by your carrier is your responsibility. Your insurance policy is a contract between you and your insurance company. You are responsible for verifying if providers are in-network with your insurance company. It is your responsibility to know your insurance benefits as it may not cover all of the services provided to you. It is the responsibility of the patients to keep their medical record updated with current address and insurance information so that the billing can be done in a timely manner. Some insurance companies require claims be submitted within 30-60 days and if new insurance coverage is not provided prior to services, it will not be possible for us to bill or collect from your insurance carrier. We will bill your insurance as a courtesy to you; however you are responsible directly to Berks Schuylkill Respiratory Specialists/The Sleep Health Center for payment of your account if there is a problem with your insurance.

DEFINITIONS

CO-PAYMENT: A fixed dollar amount that is set by your insurance contract that is required to be paid at the time of an office visit. This is a set amount and is usually noted on your insurance card.

DEDUCTIBLE: An annual dollar amount established by your insurance plan that is deducted from insurance benefits. This amount is your obligation.

CO-INSURANCE: A percent set by your insurance plan that is deducted from your insurance benefits. Co-insurance charges will be billed to you after your insurance has processed your claim.

SELF-PAY: A patient that does not have any valid health insurance. You will be asked to pay for services at the time of your appointment, unless prior arrangements have been made.

SLEEP STUDIES

When scheduling a sleep study with our office we will call your insurance company to verify your coverage. We will also verify if the study is a covered benefit under your policy, and if any deductible will be applied to the charges. For patients with a high deductible that has not yet been met we will ask the patient for a deposit of up to $500.00 to be paid prior to the study being done. If a deposit cannot be paid in advance then you will need to contact the billing department to set up an agreement. Our billing can be reached at (610) 685-5864 ext 155. If the insurance processes the claim and there is any unused portion of the deposit, this will be refunded back to the patient.

MINOR (PATIENTS AGED 17 AND YOUNGER)

The person bringing the child into the office shall be responsible for any out of pocket expenses due at the time services are rendered. Being that our office is neither an agent of any court nor a part of any ongoing litigation between parents, our office shall not be held responsible for the enforcement of any custody arrangements.

RETURNED CHECKS

A returned check fee will be applied to the account in the event of a check returned by the responsible entity's financial institution. Currently the fee is $25.00, in addition to this fee, the amount previously paid will be reapplied to the account.

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CO-PAYMENT HANDLING FEE
There will be a charge of 10.00 added to each co-pay which is not paid at the time of the visit.

SPECIAL BILLING
Berks Schuylkill Respiratory Specialists/The Sleep Health Center will gladly submit your claims regarding a motor vehicle injury, personal injury, or work related claim provided correct and updated insurance is supplied to our office. In addition we will need the name, address and phone number of your attorney if you are being represented by one.
If the insurance carrier does not pay on the claim and we are unable to get a letter of protection from your attorney the balance will be the patient's responsibility.

FORM COMPLETION FEE
There is a $10.00 fee for all forms to be filled out.

MISSED APPOINTMENTS
There is a $30.00 charge for missed appointments that have not been cancelled with at least 24 hours notice unless otherwise determined by Administration for extenuating circumstances.

For our allergy patients, there is a $10.00 no show fee for all shots given at either location.

OUTSTANDING BALANCES
If you are unable to pay in full your responsibility, you may choose to arrange a payment plan. Please talk to one of our billing representatives in the billing department to arrange a plan. Our billing can be reached at (610) 685-5864 ext 155. Payment plans may not be extended to patients who have failed to make timely payments in the past.

COLLECTIONS
Failure to pay on an existing account balance or no payment within a 90 day period will result in collections proceedings. Once an account is placed with an outside collection agency you will no longer be seen by our office until the balance is paid to that collection agency. In addition, all future services on an account that has been returned from a collection agency will be on a CASH ONLY basis. If you are unable to comply, your appointment will be rescheduled.

PATIENT CONSENT
I authorize the release of any medical information necessary to process my insurance claims. I authorize payment of medical benefits to Berks Schuylkill Respiratory Specialists/The Sleep Health Center. I authorize Respiratory Specialists, the holder of protected health information about me, to disclose this information to HGSA Administrators, a CMS contracted carrier or my insurance company to determine benefits payable for related services. I understand that I am financially responsible for all charges not covered by my insurance. I understand that co-payments and deductibles not paid by insurance will be the responsibility of me, the patient.
I understand and accept the Berks Schuylkill Respiratory Specialists/The Sleep Health Center payment policy.

Pat Whole Name (First Name First)

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Sign patient signature

Witness signature