Financial Policy

Payment is due at the time services are rendered. Allergy and Asthma Centres of the Metroplex requires all patients to pay their deductible, copay and/or coinsurance or 'self-pay' payment at the beginning of each visit by debit card (EFT), credit card, CareCredit, cash or check.

As a courtesy, we verify your medical benefits with your insurance company, however, a quote of benefits is not a guarantee of benefits or payment. If your claim processes differently from the benefits that were quoted, the insurance company will not honor the benefit quote we received.

At the conclusion of your visit with us, you may be billed for any outstanding balances. If there is a credit, you will be provided a refund immediately. You are responsible for all outstanding charges incurred and our verification of your insurance benefits is not a guarantee of payment.

Refund Policy

Allergy and Asthma Centres of the Metroplex has **a no refund/ no return policy** for any services that have been rendered.

RE: Antigen (Allergy Shots [SCIT]/Sublingual Immunotherapy [SLIT]): Antigen is custom made-to-order for each patient and cannot be used for any other patient or re-stocked. You may choose to cancel a consent for antigen in writing and issued a refund in the full amount ***if*** the antigen ***has not*** been compounded. Once antigen has been compounded it is a service that has been rendered and payment will not be refunded.

In the case of an overpayment, if the payment has not been posted to the account, a refund will be provided promptly. If the payment has been posted to the account and all pending claims have processed, the patient may request a refund in writing.

Allergy and Asthma Centres of the Metroplex has informed me (the patient or responsible guardian of the patient) that all payments will be collected on the same day services are rendered. I recognize that the acceptance of my insurance does not place all financial responsibilities onto this practice, and I will be held accountable for any unpaid balances by my plan. I understand that this practice has a no refund/ no return policy for any services that have been rendered and I must cancel my consent for antigen in writing before it has been compounded to ensure a full refund. I acknowledge and agree to these terms.

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Print Patient Name **Date of Birth**

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Signature of Patient, Guardian or Authorized Representative **Date**