Metropolitan Allergy & Asthma, PC
34 Sycamore Ave. Suite 1A
Little Silver, NJ 07739
Phone: (732)383-5554
Fax : (732)383-5495

2024 Financial Policy

Thank you for choosing Metropolitan Allergy & Asthma PC. We are committed to providing you with the best possible care.

Please initial each line after reading.

____**1. Insurance** - We submit claims to your insurance carrier on your behalf for the medical services that we provide to you based on the insurance information that you provide to us. We will verify your insurance policy eligibility and basic demographics at each visit. If your coverage changes it is your responsibility to notify us before your next visit so we can make appropriate changes.

- Insurance cards must be presented at check in
- Co Pays, Deductibles and Co Insurance are due at time of service **NO EXCEPTIONS**

_____**2. Referral**s - Your insurance may require a referral from your Primary Care Physician to be seen by a Specialist. This must be obtained at least 72 hours prior to your visit. Please check with your Primary Care Physician to confirm it has been issued. We will not be able to see you without a referral and your appointment will need to be rescheduled.

____ **3.Self Pay Patients** - Payment is expected at the time of service **NO EXCEPTIONS**. No payment plans are offered for self pay patients.

____**4**. **Non Payments**- If your account is over 90 days past due you will have 14 days to pay your account in full.,unless a payment plan has been put in place in advance. Patient's with balances that have not made a payment in 30 days will need to make a payment of 50% up front then a payment plan can be set up for the remaining balance before they see the Dr. Hajee.

____**5. Missed Appointments**- In order to provide the best access for our patients, we require 24 hours' notice for cancellations. Adequate notice allows us to provide the best possible access for sick calls and patients that need immediate care. Failure to provide 24 hours' notice may result in a $50 fee.

___ **6**. **Return Check Fee** $25

Thank you for taking the time to review our policies.

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Signature of the patient or responsible party Date