Juan L. Sotomayor, MD, PC
ALLERGY & ASTHMA
Diagnostic Office

5229 Witz Drive · North Syracuse, New York 13212 ·

(315) 701-9500 · FAX (315) 701-9555

www.allergyaway.com

Juan Sotomayor, MD · Jill Agne, FNP · Summer Goetz, FNP · Katie Klee, FNP · Anna Salvagno, FNP

Financial Policy

Once all completed forms have been received and reviewed, our office will contact you to schedule your New Patient Appointment.

Appointments and Policies

Please refer to the "Notice of Cancellation Policy and No-Show Fee" for details.

Reminder calls are provided as a courtesy.

**You will receive instructions regarding our Testing Appointments Policy.

Please carefully review all medication instructions included in your packet. Certain medications must be stopped prior to allergy testing. If instructions are not followed, testing may need to be rescheduled.

Patients under the age of 18 must be accompanied by a parent or legal guardian (or provide written parental consent) for all visits. The accompanying adult is responsible for providing current insurance information and payment of any co-pays, co-insurance, or deductibles due at the time of service. Please note that we do not become involved in custody or divorce disputes.

Emergency Coverage

Our providers are available after hours through our answering service for emergency medical Concerns only.

Please note: Routine prescription refills are not handled after office hours.

Insurance and Financial Information

Please verify with our office whether we participate with your insurance plan, as participation can change.

It is the patient's responsibility to understand their insurance benefits.

Patients are responsible for balances in accordance with their insurance plan benefits.

Medical Records Requests

Your privacy is important to us. Written authorization is required to release medical records. Please allow up to 14 business days for processing. Paper copies -$0.75/page.

Patient Responsibilities

To help ensure accurate billing and timely claims processing, we ask:

Bring all current insurance cards to every visit

Provide a valid photo ID (required to help prevent insurance fraud)

Obtain all required referrals prior to your appointment (if your plan requires one). Appointments without proper referrals may need to be rescheduled and may incur charges.

Notify us promptly of any changes to your insurance or contact information

Please understand that our relationship is with you, not your insurance company. All charges are the patient's responsibility. If an insurance company has not paid within 60 days, the balance becomes due from the patient. You are welcome to request a cost estimate prior to your visit.

Payments and Billing

Co-pays are due at the time of service. A $20 billing fee applies if co-payments are not paid at the visit.

Patients with high-deductible plans should be prepared to pay deductible and co-insurance amounts at the time of service.

Billing Statements & Collections

A $5 monthly billing fee applies to balances over 30 days

Patient statements are primarily delivered electronically for faster access.

We understand financial hardships can occur. Please contact our billing office if you need assistance. We are happy to discuss payment arrangements when appropriate.

Assignment of Benefits and Acknowledgement

By signing below, I acknowledge that:

I have read and understand the AADO Financial Policy

I authorize release of medical information necessary for insurance billing

I authorize payment of benefits directly to my provider (when applicable)

I understand that no-show fees are not covered by insurance and must be paid before future appointments can be scheduled

I understand that supplies purchased in the office are not billable to insurance and are due at the time of service

I understand I am ultimately responsible for all charges on my account

I agree to notify the office of any insurance or health status changes

If my account is sent to collections, I agree to pay collection fees (greater of $25 or

30% of balance), plus any applicable attorney fees

Acknowledgement of Financial Policy

We are honored that you have chosen Allergy & Asthma Diagnostic Office for your care. Our goal is to provide excellent medical care while also being transparent about financial responsibilities. If you have any questions about this policy or your account at any time, please do not hesitate to contact our billing team—we are always happy to help.

Patient Name (Printed): _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature (for < 18): _____ Date: _____

Relationship to Patient: _____