

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

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## Financial Policy

### Welcome to our Practice!

Thank you for taking the time to complete and return your new patient paperwork. Once all completed forms have been received and reviewed, our office will contact you to schedule your New Patient Appointment.

Dr. Juan Sotomayor is specialty trained and Board Certified in Allergy & Clinical Immunology and Pediatrics. Our care team also includes Nurse Practitioners Jill Agne, FNP, Summer Goetz, FNP, Katie Klee, FNP, and Anna Salvagno, FNP. We request that all patients maintain a primary care provider. We care for patients from infancy through retirement. If you have any questions or concerns, please do not hesitate to reach out. We are here to help and look forward to caring for you.

### Location:

5229 Witz Drive  
North Syracuse, NY 13212  
Phone: (315) 701-9500  
Fax: (315) 701-9555  
Website: www.allergyaway.com

### Appointments and Policies

- We require 24-hour notice for all appointment cancellations. Please refer to the "Notice of Cancellation Policy and No-Show Fee" for details.
- At your first appointment, 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.
- Reminder calls are provided as a courtesy. It is ultimately the patient's responsibility to know and attend scheduled appointments.

### 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.

We do not participate with:

- Excellus government plans

- Medicaid
- Medicare
- Total Care
- UHC government products
- Workers' Compensation
- NYS Marketplace Plans We accept:
- Commercial Excellus BCBS plans
- Fidelis Metal Level plans only

All other Marketplace plans are considered out-of-network. If your insurance changes, including secondary coverage, you must notify our office immediately. If you are seen with an out-of-network plan, services will be considered self-pay.

Payment of your bill is considered part of your treatment. It is the patient's responsibility to understand their insurance benefits.

### **Usual and Customary Fees**

Our fees reflect the usual and customary rates for this region. Patients are responsible for balances in accordance with their insurance plan benefits. Patients may be responsible regardless of insurance determinations.

### **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 are billed at \$0.75 per page.

### **Patient Responsibilities**

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

- 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 may apply if co-pays are not collected at the visit.
- Patients with high-deductible plans should be prepared to pay deductible and co-insurance amounts at the time of service.
- We submit claims to most insurance plans when:
  - All forms are completed and signed
  - We have a copy of the insurance card
  - Coverage is verified
  - The plan is the patient's primary insurance
- For most out-of-network plans (excluding TriCare), we may submit claims as a courtesy; however, payment is due at the time of service, and reimbursement will be made directly to the patient.

### **Billing Statements & Collections**

- Statements are sent for any remaining balances
- A \$5 monthly billing fee applies to balances over 30 days

- Billing disputes must be submitted within 30 days of the first statement
- Accounts unpaid after three billing cycles may be sent to collections, and associated collection fees will apply.

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 (Rev. 01/2026)**

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.

By signing below, you acknowledge that you have received, read, and understand the Financial Policy and agree to comply with the terms outlined. You understand that you are ultimately responsible for all charges for services rendered, including any balances not paid by your insurance.

You also authorize the release of medical information necessary to process insurance claims and authorize payment of benefits directly to the provider when applicable.

Patient Name (Printed): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature (for < 18): \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_