Eckardt Johanning, M.D., M.Sc.
Occupational and Environmental Life Science –
Fungal Research Group, Inc. (FRG)
4 Executive Park Drive, Albany, NY 12203
Phone: (518) 459-3336 | Fax: (518) 459-4646

FINANCIAL AGREEMENT

I, _____, have requested treatment from the
Patient name/ Guardian name
office of Dr. Eckardt Johanning M.D., M.Sc., PhD, and have read and understood the following:

1. I am responsible for all copayments, deductibles and co-insurance as per the terms of my contract with my insurance carrier.
2. **All copayments must be paid at the time of service.** This includes multiple copayments for testing (if required by my insurance carrier) as well as predetermined coinsurance (i.e. for allergy injections.)
3. I am responsible for obtaining any and all required referrals of service.
4. I am responsible for all non-covered services. The office will do its best to inform me of any service that will not or may not be covered. However, I understand that benefits are not determined by my insurance carrier until *after* the claim is submitted, therefore, there is no guarantee of payment by my insurance carrier.
5. I am responsible for updating my health insurance information with the office any time the information changes/terminates/new coverage begins. The office will submit my medical claims for me as per the terms of the contract with my insurance carrier.
6. The office is restricted to a "timely filing" period. I understand that I must provide my health insurance carrier information in a timely fashion, so that the claim may be paid. Any claim unpaid because I did not supply the office with my information in a timely fashion is my responsibility and I am responsible for payment.
7. Payment plans are available based on financial necessity. I understand that I must speak with the *Billing Manager* or the *Office Manager* to establish a payment plan.
8. Fees associated with testing, prepared at my request or due to insurance regulations, are my responsibility.
9. A check returned from my financial institution is subject to a returned check fee. This fee is based on the current rates set by the office's financial institution. This current rate may be obtained by calling the Billing Manager.
10. There is a nominal fee for the completion of patient requested forms such as AFLAC, disability, etc. This fee does not apply to Worker's Compensation paperwork.
11. Any account balance over 60 days old is subject to collections proceedings. A $20.00 processing fee will be assessed to an account each time a balance is turned over for collections. My account may be reported to the major credit bureaus if I do not pay this balance.

_____ **Date Signed** _____
Patient Signature/ Name

Guardian Signature
_____