Thank you for choosing our practice. We are committed to providing you with quality and affordable health care. Some of our patients have had questions regarding patient and insurance responsibility for services rendered; we have developed this financial policy. Please read it, as us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance: We participate in most insurance plans. We will bill your insurance company as a courtesy to you. Although, we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. We are NOT a party to that contract.

Referrals: If you have an HMO plan with which we are contracted, you need a referral authorization form your primary care physician: If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled. If you choose to keep the scheduled appointment without a referral, you will be responsible for full charges to be paid that day and to also sign a waiver.

Co-Payments and Deductibles: All Co-Payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Non-Covered Services: Please be aware that some and perhaps all of the services you receive may be non-covered considered reasonable or necessary by Medicare or other Insurers. You must pay for these services in full at the time of visit.

Proof of Insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help your receive your maximum benefits.

Methods of Payments: We accept payment by cash, check, VISA, Master Card, American Express, Care Credit and Discover

Patient Statement: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Guarantor: I authorize release of any medical information necessary to process claims for services rendered, assign, transfer, and set to Ear, Nose, Throat & Allergy Specialist all rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize payment of these benefits to Ear, Nose, Throat & Allergy Specialist. I accept responsibility for any balances unpaid by my insurance company.

I hereby give my consent for Ear, Nose, Throat & Allergy Specialist to use and disclose protected health information (PHI) about me to carry out treatment, billing, and routine healthcare operations of this medical practice. I have read the Notice of Privacy Practices, which provides a more complete description of such uses and disclosures.

Nonpayment: If your account is past due, you will receive a letter from us stating you have 10 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. If this is to occur, you will not be able to be seen in the office until your balances paid in full and all charges for future visits will be collected upfront. Until the balance is paid in full, our physicians will only be able to treat you on an emergency basis for a previously treated injury or problem.

Returned Checks: There is a fee of $35 for any checks returned by the bank.

Divorce: In case of a divorce or separation; the party responsible for the account is the parent authorizing treatment for a child. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Worker's Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification form your attorney prior to your initial visit. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

FMLA paperwork can take up to two weeks for completion and a fee of $50.00 will be charged.

Missed Appointments: Our policy is twenty-four hour notice on an appointment change. We understand emergencies arise. If an emergency keeps you from keeping your appointment, please contact us as soon as you know you will not be able to keep the scheduled appointment. Please help us to serve you better by keeping your regularly scheduled appointments.

Medical Record Copies: You will need to request in writing, and pay a reasonable copying fee. Currently $0.97 per page up to $35.00. There also may be a $20 added charge if the chart must be retrieved from storage.

Our practice is committed to provide the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Signature of Patient/Parent/Legal Guardian:____.Date:_____________________

Ear, Nose, Throat & Allergy Specialist