ENT Associates

FINANCIAL POLICY

As a courtesy to you, our patient, we will file your insurance for you. However, since the coverage is a contract between you and the insurance company, it is ultimately the patient's responsibility to ensure that services are paid in a timely manner. If your procedure is a non-covered benefit, according to your insurance policy, it becomes an expense billable to you.

If you are a member of an HMO, ***IT IS THE PATIENT'S RESPONSIBILITY*** to obtain any and all necessary referral authorizations **PRIOR TO YOUR VISIT**. If the authorization is not in our office at the time of service, it may be necessary to reschedule your visit if you choose not to pay at the time services are rendered.

All co-payments, deductibles and co-insurance amounts are due at the time of service. They are payable by check, cash or credit card (Visa, Mastercard, Discover, or American Express). If a check is returned by your bank for any reason, you will be charged a $39.00 Returned Check Fee, which will be added to your account, and must be paid in full by either cash or credit card prior to any follow up visits.

If you require FMLA paperwork to be completed by one of our Physicians, there will be a charge of $35.00 payable the day you pick your paperwork up from the office.

There will be a fee of $25.00 charged to your account for any missed appointments that are not cancelled 24 hours in advance.

If you are a SELF PAY PATIENT with no insurance coverage, all fees are due and payable at the time services are rendered, unless prior arrangements have been made with our Billing Department.

It is our policy to obtain all pertinent information in order to identify you as our patient. Included is your social security number and a copy of your driver's license or photo identification. This information is protected by the HIPAA laws.

If you are a PARENT / GUARDIAN OF A MINOR, it is the responsibility of the parent who is seeking treatment for the child to ensure that payment is rendered accordingly.

By signing below, I understand that I AM RESPONSIBLE FOR PAYMENT OF SERVICES PROVIDED. If for any reason I am delinquent in my payments, I will be responsible for the Collection Fee of 30% and the outstanding balance on my account, plus any attorney's fees.

I ACKNOWLEDGE RECEIPT OF THIS FINANCIAL POLICY AND A COPY SHALL REMAIN IN MY CHART.

RELEASE OF INFORMATION

By signing below, I authorize the Physicians of Ear, Nose & Throat Associates to release any information with regard to my treatment, for insurance purposes. I also authorize the above physicians to release my information to other physicians or institutions as necessary for my treatment.

I understand that any information given with regard to my treatment shall remain CONFIDENTIAL and will be released only as necessary to my care or treatment.

Signature _____ **Date** _____

Print Name _____