FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

A CURRENT GOVERNMENT ISSUED PHOTO ID AND CURRENT INSURANCE CARD (IF REQUESTING US TO BILL YOUR INSURANCE) MUST BE PRESENT AT INITIAL VISIT. FAILURE TO PROVIDE EITHER OF THESE MAY REQUIRE US TO RESCHEDULE YOUR APPOINTMENT. IT IS OUR PRACTICE POLICY TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR OUR FILES.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE PHYSICIAN.

APPOINTMENTS
24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee of $25 will be added to your account at the discretion of each office.

REFERRALS
If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, we will reschedule your appointment.

EXPECTED AMOUNT DUE
By law we MUST collect your carrier designated co-pay/co-insurance and/or deductible. This payment is expected at the time of service. Please be prepared to pay the expected amount due at each visit. We will not bill an insurance company if we do not have a copy of your current card and a valid photo ID at the time of visit. We bill primary and secondary insurances only, as a courtesy. If we are unable to verify your benefits, then you will be responsible for following up with your insurance.

MEDICARE
We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

OUT OF NETWORK PLANS
You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-pay, co-insurance and deductible. If we do not 'participate' with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days; you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the appropriate physician's office.

SELF-PAY PATIENTS
Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. All arrangements made for services will require an agreement signed by both patient and administrative staff. Failure to adhere to practice policy will result in collection proceedings.

ENT PROCEDURE
Your insurance company requires that we bill our services to you using a coding system known as CPT (Current Procedural Terminology). Many codes that Otolaryngologists use to describe the service performed are found in the "surgery" section of the CPT code book. This does not mean that you had an operation. This is merely the way the CPT book is organized for ease of use by both the insurance companies and physicians. Your Insurance Company may cover the care rendered for "surgical" codes differently than for office visits. Therefore, your insurance explanation of benefits may reflect that the service was paid as a surgical procedure, with deductible and co-insurance guidelines applied. We encourage all of our patients to check with your insurance company and verify your benefits.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS, DISCOVER CARD OR CARE CREDIT

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name _____ DOB _____

Responsible Party Signature _____ Date _____

Print Name _____ Relationship _____