Ear, Nose, Throat and Allergy Clinic, S.C

Patient Name: ____ Birthdate: ___/___/____

General Financial Policy:

- In order to be able to provide the best medical care, payment is expected when services are rendered.
- If you do have insurance, we will submit charges to the **insurance that is presented at time of visit**.
- It is your responsibility to notify our office of changes in your insurance/address, otherwise you will be considered a self-pay patient and you will be responsible for submitting to the correct insurance **on your own**. Please bring your insurance card and a valid photo ID with you to each appointment.
- The co-pay and deductible amounts are due at the time of visit. If you arrive without your co-payment/insurance card we may ask you to reschedule.
- Patient responsible amounts are due when you **check in** for your appointment.

Patient Initials __________

- There will be a **$25**rebilling fee applied monthly to past due accounts.

Patient Initials __________

- After **90 days** unpaid accounts are automatically transferred to a collections agency and we reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, or terminate you as a patient of this practice.

Patient Initials __________

- Patient balances are required to be in paid in full prior to allergy testing, allergy serum preparation, allergy shots and/or elective surgery.

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Patient Initials __________

Cancellation of Appointments:

- Cancellation of appointment is required twenty-four hours in advance of scheduled appointment. If our office is not notified, this will result in a **$35** fee. Multiple failures to give a twenty-four hour notice may result in no future appointments.

Patient Initials __________

Medical Record Copying:

- All medical record copy requests must be in writing, dated, signed, designated as to where the records are to be sent and what record documents are to be copied along with reason for request. Medical information is accessible to the patient or their representative with signed authorization. There are associated costs with these services.

Patient Initials __________

Non-Sufficient Funds (NSF):

- Service fee of **$25** will be assessed for first check. Second NSF will result in a $50.00 service fee and patient will be on a cash payment method only status. Any further failure to pay service with legal tender may result in dismissal from the practice.

Patient Initials__________

Authorization and Release:

- I authorize release of any information concerning me (**or** my child's) medical care for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the provider.

Patient Initials __________

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

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Patient's (Legal Guardian's) Signature Date