Ear, Nose & Throat Associates, P.C.

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to providing high quality care and payment of your bill is considered part of your treatment. The following is a list of guidelines that are necessary to make your visit as successful as possible.

PATIENT RESPONSIBILITY:
It is your responsibility to provide us with the correct information to bill your insurance plan(s). We will collect your deductible, coinsurance, copay, or charge for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. We accept cash, checks, credit/debit cards, and CareCredit.

INSURANCE:
It is not an easy task to interpret each individual insurance policy due to the many different insurance carriers that our patients have. Please remember that your insurance policy coverage is between you and your insurance company. Therefore, it is your responsibility to know your individual coverage. Please check with your insurance company prior to any visit or procedure being performed for specific coverage details.

If your insurance requires a referral, it is your responsibility to obtain that prior to your visit. As a courtesy we will reach out to your PCP to help coordinate this. However, if your claim is denied for no referral, you are financial responsible for the balance.

We cannot guarantee payment of claims billed to your insurance. If your insurance company pays only a portion of the bill or denies your claim, an explanation of benefits will be sent to you. Reduction or denial of your claim by your insurance does not relieve you of your financial obligation to pay the bill.

The balance on your account is your responsibility. Please keep in mind that some, and possibly all, of the services provided may be non-covered services. Also be aware that some services may not be considered medically necessary or may be deemed experimental by Medicare or other medical insurance plans, in which case you will be liable for the balance.

OUT OF NETWORK:
While we participate with most insurance plans, there are some plans our practice is not in network with. We do our best to make you aware of this prior to your visit, but it is your responsibility to know your insurance coverage. If the services rendered are not covered or only partially covered due to an out of network status, the balance is your responsibility.

SELF-PAY PATIENTS:
Patients with no insurance will be expected to pay in FULL at the time of service.

MEDICARE PATIENTS:
We are participating providers with Medicare and will bill Medicare for all your covered charges. If you have supplemental insurance, we will also bill that for you. We may collect 20% of charges at the time of your visit.

MINORS:
It is the parents' responsibility to notify us of any special payment arrangements between parents; by default, whoever brings in a patient under the age of 18 is responsible for the balance. Patients under the age of 18 must be accompanied by an adult, preferably the parent(s) or guardian, in order to be seen.

NO SHOW or MISSED Appointments:
We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call or text 24 hours in advance to cancel. If you do not notify us, you may be charged a no-show fee. If three appointments are missed, you will be dismissed from the practice for non-compliance.

ADDITIONAL SERVICES/CHARGES
If deemed medically appropriate, your visit may include an additional procedure(s) that is separately billable from the visit charge. These procedures include, but are not limited to: hearing tests, scopes, ear cleanings, Epley maneuvers, biopsies, FNAs, and excisions.

PAPERWORK:
There is a $15.00 charge to fill out your 1st sick leave/disability paper and $5.00 for each form thereafter. This must be paid when you drop off your paperwork. Please be sure to fill out your portion and indicate whether the form(s) should be faxed or mailed.

COLLECTIONS:
If your account becomes delinquent from non-payment, we will turn it over to a collection agency with a fee (30% of balance) that you will be responsible for. At that time, you will be dismissed from the practice for non-compliance.

RETURNED CHECK FEES:
There is a $15.00 service charge on all bounced (NSF) checks that will be your responsibility to pay in addition to the original charges the check was for.

ASSIGNMENT OF BENEFITS AND RELEASE OF RECORDS:
You do hereby assign to us, the medical benefits to which you, or your dependents, are entitled. You also authorize us to furnish to your insurance company all of your patient information, including but not limited to: any and all medical records, notes, test results, imaging reports or other documents related to your treatment (including itemization of any charges and payments on your account) that is deemed necessary to process this claim. You also authorize us to release any and all patient information and medical records, necessary to collect this debt. Similarly, you authorize us to contact your insurance company, lawyer, or anyone else directly affiliated with your claim in order to collect this debt.