Ear, Nose & Throat Associates, P.C.
3455 Regency Park Drive, Grand Blanc, MI 48439
tel: (810) 694-0600 – fax: (810) 694-0601
www.michiganENTdoctors.com

Steven Reschak, D.O.
Monika Chmielewska, D.O.
Cynthia Hayes, D.O.

REFERRAL POLICY

Patient Name: _____ Acct #: _____

Your insurance requires a referral be in place in order for your visit to be covered and we have not received a referral for today's visit.

As a courtesy to our patients, we always reach out several times to your PCP to secure a referral prior to your visit. As of today, they have not provided the referral despite several requests from our office. It is ultimately the patient's responsibility to obtain a referral and we reserve the right to reschedule your appointment because of this.

However, we don't want to delay your care so we are willing to see you but we want to make you aware that if a backdated referral is not obtained, you will be financially responsible for today's visit as well as any additional procedures/services that are performed. As such, we require that a credit card be put on file as part of the agreement to be seen today without a referral in place.

Billing Terms

1. We will bill out today's visit to your insurance, regardless.
2. If a referral **is not** received within 30 days of your visit and the claim is denied by your insurance, we will run your card for the total amount due based on our discounted self-pay rates.
    a. In the event that we receive a backdated referral after we have charged you self-pay rates, we will re-bill on your behalf and refund the full amount, minus any cost sharing due by you.
3. If a referral **is** received before 30 days and the claim is approved by your insurance, we will run the card for any outstanding balance owed do to cost-sharing (copay, coinsurance or deductible). If no balance is due, the card will not be run.

Please note it is your responsibility to notify us if a backdated referral has been issued so that we can re-bill your insurance.

By signing below, I acknowledge that I have read and understand this agreement. I agree to the financial terms outlined above and authorize ENT Associates to run my credit card in accordance of the terms of this Policy.

Patient/Guardian Signature: _____ Date: _____

Cardholder Name: _____

Card Number: _____ Security Code: _____ Exp Date: _____

☐ Check if card info was entered directly into ModMed