



## FINANCIAL POLICY

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Thank you for choosing Eastern Shore Ear, Nose and Throat Clinic for your medical care! We are committed to your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. For your convenience, we have answered a variety of commonly asked financial policy questions below. If you have any questions or need further clarification about any of these policies, please ask to speak with a Billing Specialist or the Practice Manager.

### **How May I Pay?**

We accept payment by cash, check, and major credit cards. Returned checks are subject to a service charge of \$35.00 and you will lose the privilege to write checks in our office.

### **Do I Need a Referral?**

If you have an insurance policy that requires a referral that we are contracted with, you are responsible for obtaining the referral authorization from your primary care physician; without an insurance required referral, the insurance company will deny payment for services. As such, you may be asked to reschedule if you are unable to obtain the referral. \*All uninsured patients require a referral from a physician to be seen.

### **Proof of Insurance**

Please bring your insurance card(s) and a valid photo ID with you to each appointment. It is your responsibility to notify the Practice of changes in your health insurance, address, phone number and choice of pharmacy.

### **Office Visits and Office Services**

Patients presenting to our offices with sinus, allergy, throat, hearing, or voice complaints require a thorough examination of that specific area. In some cases, this can only be accomplished using diagnostic tests or procedures. The tests and/or procedures are separate from the physician's office visit/consultation and thus have a separate charge.

The following is a list of the tests/procedures that may be performed or ordered:

- Audiogram (Hearing Test) · Balance Testing · Laryngoscopy (Throat Scope) · Nasal Endoscopy (Nasal Scope)
- Ear Cleaning · Sinus Cleaning (debridement) after sinus surgery · Minor Surgical Procedures and/or biopsies

**(Your insurance may list these procedures as surgery on your explanation of benefits. These procedures may also be applied to your deductible which may result in you receiving a bill from our office.)**

### **Surgery**

If your physician recommends surgery, our Surgery Coordinator will contact you. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it. The Surgery Coordinator will request a pre-surgical deposit, the amount of which depends on your coverage and deductible amount.

· **Please see reverse side →**

**What is My Financial Responsibility for Services?**

Your financial responsibility depends on a variety of factors. Insurance is not a guarantee of payment. Many times, after filing a claim your insurance carrier may apply more to patient responsibility. Our office will be happy to send you a statement with your responsibility for services rendered. If payment is not received after the 3<sup>rd</sup> billing statement or you have not setup a payment arrangement your account may be turned over to our collection agency. In the event it is necessary to send your account to a collection agency to collect your debt you will be responsible for any collection fees.

**Insurance & Financial Authorizations**

Payment is due at the time services are provided unless other options or plan(s) have been made prior to visit. I understand that I am responsible to be knowledgeable of my insurance coverage, deductible, and co-pays for any service provided to me and that I am financially responsible for payment to Eastern Shore, Ear, Nose and Throat Clinic. Refunds if owed from services charged will be issued only if there are no other outstanding debts on account. Refunds will be issued in the form of a check.

**Treatment Authorization:** I hereby give Eastern Shore Ear, Nose and Throat Clinic consent for medical treatment.

*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/Guarantor Signature

Printed Name

Date