

**EAR, NOSE & THROAT ASSOCIATES, P.C.**

**Attention All Patients**

FINANCIAL PAYMENT POLICY

Thank you for choosing us as your health care provider. We are committed to your medical treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you read and sign prior to any treatment.

All patients must complete our information and insurance form before receiving treatment.

**IMPORTANT:** It is important that you give us complete and accurate insurance information prior to obtaining services. It is also important that you keep us informed of any changes. Please do not give us only a phone number and expect us to gather your information. **We must have the insured member's address, social security number, birth date and employer, as well as a copy of the insurance card.**

1. **REGARDING INSURANCE:** If you have a policy which requires pre-authorization or a referral for medical treatment it is your responsibility to make sure that authorization is obtained. Please contact either your primary care physician or your insurance company to complete that.

We will file your medical insurance and we may accept assignment of insurance benefits from your health care plan, but your insurance policy is a contract between you and your insurance company. Any unpaid balance or denial is **your** responsibility. "Remember" these services are provided directly to you and not your insurance company.

If we are a participating provider in your insurance plan, all co-payments and deductibles are due prior to treatment, including Medicare and TennCare. **This means that co-pays and deductibles will be collected up front during the check-in process.**

2. **METHODS OF PAYMENT:** We gladly accept cash, checks, visa, mastercard and discover. This office understands special needs and we offer a pre-approved extended payment plan.
3. **USUAL AND CUSTOMARY RATES OR NON-COVERED SERVICES:** Our practice is committed to the best treatment for our patients and we charge what is usual and customary for our area. Please be aware that some of the services provided may be non-covered services and not considered reasonable and customary under the Medicare Program and/or other medical insurance. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary. You are also responsible for any non-covered services.
4. **MISSED APPOINTMENTS:** Unless canceled at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments. We also reserve the right to terminate your care if you miss 3 appointments within a year.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We are here to help.

I have read this financial policy. I understand and agree to this financial policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date