ent specialists pc℠

Financial Policy

Thank you for choosing ENT Specialists, P.C. for your ear, nose, and throat care. The following is a statement of our financial policy. All patients must accept our financial policy before receiving treatment.

Insurance

- As a courtesy to you, we will submit medical claims to your insurance company. Any balance after processing of our claim by your carrier is considered your responsibility.
- We cannot bill your insurance company unless you give us your complete insurance information.
- **All co-pays are due prior to appointment.**
- If you belong to an HMO plan, you are responsible for making sure a referral is completed and at our office before your appointment.

Surgery

- We require payment of the dollar amount of your unfulfilled contracted insurance deductible seven days prior to your scheduled surgery date.
- We reserve the right to cancel all elective surgical procedures if the deductible has not been paid.

Payment

- We accept cash, check, Visa, MasterCard, and Discover. Payment plans may be arranged on a pre-approved individual basis.
- A $35 service fee will be charged for all checks returned for insufficient funds. You will also be required to prepay in full using cash or credit card for future services.
- All unpaid accounts will be forwarded to a collection agency after 90 days.

Disclosure of Physician Ownership

The physicians of ENT Specialists, P.C. have an ownership interest in Midwest Surgical Hospital, L.L.C ("M.S.H."). You have the right to choose the provider or facility for your healthcare services. Therefore, you have the option to use a healthcare provider or facility other than M.S.H, if you are recommended for surgery.

HIPAA Privacy Practices Notice

Release of Information: I hereby authorize the release of medical records both written and oral, to insurance companies, employers, physicians, HCFA, and any other institution or organization that may request information necessary to determine eligibility for healthcare benefits. I request that payment of authorized Medicare and insurance benefits be made to ENT Specialists, PC or me. I hereby acknowledge that I was offered a copy of the ENT Specialists, P.C. HIPAA Notices of Privacy Practices.

Please list names of individuals who may be given billing/medical information:

_____

I understand and agree to the terms of all of the above policies.

I consent to the use and disclosure of protecting health information for treatment, payment, and necessary healthcare operations and have been offered a copy of the Notice of Privacy Practices.

X_____ _____ _____
Signature of patient or responsible party Print Patient's name Date

Consent to Treat

I hereby acknowledge that I/my child needs medical care and treatment. When applicable, I voluntarily consent to the treatment (examination, procedures, treatment, etc.) provided by the medical personnel in this office as well as any diagnostic services that may be deemed necessary. No guarantees have been made to me regarding the results of treatments or examinations.

Patient Signature **X**_____ Date _____

If under 19, parent/guardian signature **X** _____ Date_____


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