

**Insurance**

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. You will be asked to update your demographic and insurance information annually, including providing our office with copies of your insurance card(s). We are required to obtain your signature for permission to release information to your insurance carrier annually. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan. Please assist us in complying with your insurance requirements. We will gladly submit fees for your covered medical services to your insurance company. However, we expect payment of all services within 60 days. It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days. It is your responsibility to understand your coverage and benefits, including precertification's, referral and authorization requirements. We, however, will assist you to insure all plan requirements are met.

**Payment for services**

Payment for services, including co-payment and deductible amounts, is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. Our failure to collect these amounts may be a violation of our contract with your insurance company and may result in civil and criminal penalties and/or expulsion from you insurance plan. In addition, your failure to pay the required co-amounts is a violation of your financial responsibility for coverage and we may report your refusal to pay these amounts to your employer and/or insurance company representative. We accept cash, checks, MasterCard, VISA, Discover and Care Credit. Returned checks, balances older than 60 days, and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court fees. We may investigate your credit record to determine your ability to pay your debt.

**Cancelled Appointments**

Charges will be made for broken, confirmed appointments and appointments cancelled without 24 hours advance notice. Your cooperation in canceling your scheduled appointment well in advance of the appointment allows us the opportunity to offer your appointment to another person who needs medical care. Failure to show for a scheduled confirmed appointment will result in a \$50 cancellation fee.

**General**

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. It is important to understand we do participate in many of the local insurance plans. Your insurance, however, is a contract between you, your employer and the insurance company. We are, often, not a party to that contract. We are very sensitive to keeping health care costs affordable to our patients. As a result, we take great care to insure that our fees are consistent with the charges in this geographic region. Your insurance company may not use "reasonable charge information" specific to this region and specialty of Otolaryngology. In fact, many carriers purchase non-specific data and/or do not update their information on an annual basis. Most reputable insurance companies consider our fees usual, customary and reasonable. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We must emphasize that as the medical care providers, our relationship is with you, not your insurance company. *While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.*

**HMO/PPO:** It is your responsibility to obtain referrals or pre-authorization as required by your insurance company. Co-payments must be paid at the time of your visit.

**MEDICARE:** We will file your claim with Medicare. If you desire, we will file your secondary insurance for you once we receive payment and the Medicare Explanation of Benefits.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in management of your account. If you have any questions on the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. Thank You.

**My signature below constitutes acknowledgement and acceptance of this policy**

Signed:

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Patient or guarantor Date



## Patient Information

First name: \_\_\_\_\_ MI: \_\_\_\_ Last name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State and Zip code: \_\_\_\_\_

Phone #'s: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_

Email Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Sex: M F Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_

Referred By: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

**Reason for visit:** \_\_\_\_\_

### Responsible Party Information

Primary Insurance Co: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group #: \_\_\_\_\_ **SSN** \_\_\_\_\_

Policy Holder's Full name *(if not patient)* \_\_\_\_\_

Patients relationship to policy holder: \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Secondary Insurance Co: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group #: \_\_\_\_\_ SSN \_\_\_\_\_

Policy Holder's Full name *(if not patient)* \_\_\_\_\_

Patients relationship to policy holder: \_\_\_\_\_ Date of Birth \_\_\_\_\_

*I hereby authorize the release of medical information to insurance carriers and/or other physicians, and also for benefits to be paid directly to Balance and Ear Center, Inc. In the care of a minor, I authorize the filing of insurance claims. I understand that I am responsible for all charges (including non-covered charges) arising for the treatment of the named patient. Should this account become delinquent, I agree to pay all collection and court costs, including attorney's fees.*

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

***In case of emergency, please notify:***

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

***If patient is a minor:***

Mother's Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

City, State and Zip code: \_\_\_\_\_

Phone #'s: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_

Father's Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

City, State and Zip code: \_\_\_\_\_

Phone #'s: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_