Account #_____

Adult & Pediatric Ear, Nose and Throat

A Division of Paragon Health, PC

Financial Informed Consent

Initials

____ I understand that there are costs associated with the visit today as a specialty clinic. Those costs may be from the office visit by itself or a procedure performed while in the office (specifically Scopes, Biopsies, Ear Wax removal, and other in office procedures).

____ There are hundreds of different types of insurance companies. Each has their own premium, deductible, copay, coinsurance, and out-of-pocket cost. Each one has a negotiated contract with set prices for charges. Additionally, you could have charges above your office copay if your yearly deductible is not met.

****The office does not know the amount the charges will be as different insurance companies have different contractual amounts.**

____ Co-Payments are required at the time of the visit. We accept cash, check, or credit/debit card. Payment will include any copay amounts, non-covered charges from your insurance company, and balances due on previous services. If you do not carry insurance or if we do not participate with your insurance, payment in full is required at the time of your visit. It is your responsibility to know what your copay amount is and to pay it at check-in. Checks returned for non-sufficient funds (NSF) will incur a $25 service charge. Payment plan terms must meet internal policy guidelines and be arranged prior to the due date on your first statement.

____ We participate and file claims with several insurance companies. Insurance is a contract between the patient and the insurance company; and ultimately, the patient is responsible for payment in full. We do not participate with auto insurance. If you believe your condition is auto-related, please contact our office administrator for further assistance.

____ I understand that I am responsible to pay a $50.00 No Show Fee if an appointment is missed and I do not contact you 24 hours in advance.

____ I acknowledge that I have read (or had read to me) and understand the above statements on financial costs associated with my visit. I also understand that I may decline procedures or treatments at the time of service if I chose to.

Print Patient Name _____Birthday _____ Date_____

Signature of patient or legal guardian _____

Revised November 22, 2019