Adult & Pediatric Ear, Nose and Throat
Hearing Aid Solutions
A Division of Paragon Health, PC

Financial Policy
We seek to offer the very best care and facilities to our patients. Our financial policy is designed to aid us in continuing to provide the highest level of quality ear, nose, and throat care to our patients. Please see our complete financial policy in our office or on our website: www.kalamazooent.com.

Payment
Payment is required at the time of your visit. We accept cash, electronic 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. A $25 statement fee will be added to your balance each time your full copay is not paid at the time of your visit.** 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. _____ (initial)

Insurance
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 administrator.

Cancelations or Missed Appointments
A fee of $35 will be billed to all patients who miss or give less than 24 hour cancellation notice. *The fee must be paid before a new appointment is scheduled,* and repeated no shows and/or cancelations may result in discharge. _____(initial)

Surgeries
Payment in full is expected within 30 days of your first statement. Alternate payment arrangements can only be approved by the office manager prior to your due date. We can assist you with obtaining prior authorizations; however, it is your responsibility to make sure that required prior authorizations are in place before surgery.

Collections
Collection processes are initiated for balances exceeding 60 days past due. We will make every attempt to contact you prior to collection action; however, if we do not receive payment in full by the due date on our second statement, your account may be referred to collections. In the event that your account is placed in collections, a 35% collection fee plus letter fees will be added to your outstanding balance. You may also incur court costs, interest, and fines.

I acknowledge that I have reviewed this policy.

_____ _____
Name of Patient **Date of Birth**

_____ _____
Signature of Patient or Responsible Party **Date**

_____ _____
Relationship to patient **Date of Birth**

For Office Use Only:
We require written acknowledgement of the receipt of this financial policy or documentation of the reason it was not obtained.
*Refused to sign *Physically unable to sign
*Other:_____
_____

Employee Signature: _____ Date: _____