Petoskey Ear, Nose & Throat Specialists Patient Financial Policy

Patient Name: _____ **DOB:** _____

Thank you for choosing **Petoskey Ear, Nose and Throat Specialists** for your ENT, allergy and audiology care! We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship. We sincerely hope that by sharing our financial expectations we will strengthen the physician-patient relationship and keep the lines of communication open. If you have any questions or need clarification of any of the below policies, please feel free to contact our billing department at (231) 487-3277.

Payment is Due At the Time of Service

- We accept cash, checks, debit & credit cards and Care Credit.
- All co-payments, deductibles, co-insurance and fees for non-covered services are due at the time of service unless you have made payment arrangements in advance of your appointment.

Initial here

- Insurance required co-payments are due when you check in for your appointment. If you arrive without your co-payment, we may ask you to reschedule. We charge an administration fee of $25.00 for co-payments not paid at the time of check in.
- Patient-responsible balances are due when you check in for your appointment, unless prior arrangements have been made with our Billing Department.
- In the event you need surgery we will provide you an estimate of your insurance required deductible and co-insurance amounts which will be due as a deposit prior to your surgery.
- We request that at least **24 hour** advance notice be given to the office if you will be unable to keep your scheduled appointment and we require **10 days** advance notice for cancellation or rescheduling of major tests or surgeries. This allows us to release your time to another patient who also needs our care. We charge an administrative last minute cancellation/no-show fee of $25 per office appointment and $200 per major test or surgery. Patients who repeatedly "no show" may be discharged from the practice.

Proof of Insurance

- Please bring your insurance card(s) and a valid photo ID with you to each appointment.
- It is your responsibility to notify the Practice of changes in your health insurance.

Self-Pay Accounts

We designate accounts as **Self-Pay** under any of the following circumstances: (1) patient does not have health insurance coverage (2) patient is covered by an insurance plan that our providers do not participate in, (3) patient does not have a current, valid insurance card on file, or (4) patient does not have a valid insurance referral on file.

Initial here

Self-Pay patients, please be prepared to pay in full on the date of service. This could include the cost for the patient office visit ($90 - $350) and any additional services additional fees for in office procedures, including cerumen (earwax) removal, post-operative sinus debridement, allergy testing, allergy shots, hearing aids, or other supplies or services. If you are unable to pay, please ask to speak to the billing department to make payment arrangements prior to the date of your appointment.

Late Arrivals

Patients who arrive more than 15 minutes late for an appointment, without calling in advance, may need to be rescheduled. We strive to minimize the wait time for patients who arrive on time. We will offer you a later appointment on the same day if one is available. Our goal is to accommodate all patients as best as possible, but cannot compromise the quality and timely care provided to our other patients.

Financial Assistance

Our Practice treats patients regardless of financial status. For those who are uninsured, we offer assistance in the form of a sliding scale discount of charges based on verifiable household income. The front desk receptionist will be happy to provide you an application.

*** *Please Turn Over* ***

Our Responsibility to Report Non-Compliance

It is our obligation under many of the insurance contracts to report patients who repeatedly refuse to pay co-payments/deductibles at time of service, or who repeatedly "no show" for scheduled appointments.

Foster Care, Divorce and Child Custody

The parent or guardian who brings the child to the office for care is responsible for payment at the time of service no matter if the account is self-pay, participating insurance, or nonparticipating insurance. The Practice does not honor divorce specifics (*e.g., percentage of financial responsibility).*

If the child has coverage with a participating insurance plan and the proper insurance identification is present at the time of service, the Practice will bill that insurance company. Applicable co-payments, coinsurance, deductibles and/or outstanding balances are due at the time of service, unless arrangements have been made with the office prior to arrival.

In cases of divorce, the individual who brings a minor child for care is responsible for payment of co-payments, coinsurance, deductibles, and nonparticipating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.

Billing, Payments and Refunds

If we must send you a statement, the balance is due in full within 14 days of the statement date.

If you cannot pay the balance in full by the statement due date, please contact our billing department to make payment arrangements. Do not send in a partial payment without approval; your account will be Past Due.

It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage.

If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same guarantor or financial responsible party.

We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, or terminate you as a patient of this Practice. Collection fees are added to balances owed.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to **Petoskey Ear, Nose & Throat Specialists.**

Initial here I authorize **Petoskey Ear, Nose & Throat Specialists,** through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I authorize **Petoskey Ear, Nose & Throat Specialists** to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

I authorize **Petoskey Ear, Nose & Throat Specialists** to contact/discuss my personal health information with these individuals and/or to contact them in case of an emergency:

Name: _____ Phone: _____ ☐ Emerg ☐ Info

Name: _____ Phone: _____ ☐ Emerg ☐ Info

Name: _____ Phone: _____ ☐ Emerg ☐ Info

X Patient/
Guarantor Signature _____ Date: _____

Acknowledgement of Petoskey ENT Specialists Notice of Privacy Practices

I hereby acknowledge that I have reviewed or received or have been given the opportunity to receive a copy of **Petoskey Ear, Nose & Throat Specialists** Notice of Privacy Practices.

X Patient/
Guarantor Signature _____ Date: _____