Financial Policy

Please Initial:

_____All current balances, co-payments, co-insurance and deductibles are **due and payable PRIOR to services** being rendered and is required by your insurance to be paid at each visit. We accept cash, check, VISA, MasterCard, Discover, and American Express. Please be aware that all checks are run electronically at the time of service. We do not accept post-dated checks.

_____**REFERRALS:** If you have Medicare, a HMO, or similar plan that requires a referral, you will need a referral from your primary care physician to see our specialists. If your insurance requires a referral that is generated through them, you must reach out to your primary care for them to call your insurance. Since we are the specialist, we cannot generate a referral for ourselves. **If we have not received this referral prior to your arrival at our office, your appointment will either be rescheduled or you will be responsible for the entire bill. It is your responsibility to know if a referral is required and to obtain one.**

_____**INSURANCE BENEFITS:** Please be aware that when a patient requires a visit to a specialist, there are diagnostic procedures required for appropriate care that cannot be done by primary care physicians. These procedures may be done during the normal course of the exam by the specialist. Although necessary as part of routine exams, insurance companies often categorize these as procedures. The possible procedures which often are performed in this practice during your visit include, **but are not limited to**:

Nasal Hemorrhage Control
Nasal Endoscopy with debridement
Laryngoscopy
Cerumen (ear wax) Removal
Foreign Body Removal
Tympanometry
Audio-Comprehensive
Audio-Visual Reinforcement
Binocular Microscopy
Nasopharyngoscopy with endoscope

Depending on your insurance policy provisions, these procedures and others may fall under a separate benefit other than your office co-pay, such as a deductible or coinsurance. In most cases, exact insurance benefits cannot be determined until the insurance company receives the claim. Therefore, any estimate for services will be considered an estimate only and any payment will be considered a partial-payment only until such time that the insurance company processes your claim. Your insurance is a contract between you and your insurance carrier; payment for services is ultimately your responsibility. It is extremely important for you to know your coverage. Many of the diagnostic and therapeutic procedures performed in our office (such as endoscopy, ear wax removal, and biopsies) are considered additional costs by your insurance company. Your physicians are not aware of what additional costs may be incurred and will not review that with you. As specialists, our physicians may recommend a diagnostic or therapeutic procedure not available to non-specialist physicians in order to provide you with the best possible treatment. If you have concerns regarding the cost of any procedure, you may ask your doctor if you can discuss the cost with our business staff BEFORE the procedure is performed to decide if you would like to have it done.

_____**FORMS FEE:** Please allow 5-7 business days to complete all forms that require a physician signature and medical review (i.e., FMLA, Short-term disability (STD), other extended leave of absence, etc.) The physician must take the time to fill out the forms, there for each record requested, a $30.00 Forms Fee will be assessed. Each time a correction needs to be made to a form, another Forms Fee will be charged to the account. There is no exception to this rule. Additional medical records request will also have a $30.00 assigned fee.

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_____**NO SHOW/CANCELLATION COURTESY:** We are committed to making you an appointment at your earliest convenience; likewise, we require a call at least 24 hours in advance if you are unable to keep your appointment to allow for other patients to be seen. If you "no show" for an appointment or cancel with less than 24 hours notice, you will be charged a $50.00 fee. Multiple missed appointments may result in our request for you to find another specialist.

_____**RETURNED CHECK FEE:** There is a $35.00 fee for checks returned for any reason and will be added to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.

_____**COLLECTION AGENCY:** Please be aware that The Ear Nose & Throat Centers of Texas utilizes a collection agency for unpaid bills. If your account is transferred to collections, any and all fees assessed by the agency will be added to the balance on your account, to include, but not limited to, an additional percentage of your balance and attorney fees. Any patient sent to collections forfeits any future appointments unless the balance is paid in full but may be permanently dismissed from the practice.

_____**SURGERY DEPOSIT:** If surgery is recommended, you may be required to pay a portion of your deductible and/or coinsurance prior to the date of surgery. The deductible and/or coinsurance will be applied to your balance and will be due prior to the date of the surgery. Any quote received for surgery will be considered an estimate only and any payment will be considered a partial payment only until such time that the insurance company processes your claim. If you cancel your surgery for any reason, the deductible will be refunded.

_____**PATIENT BALANCE POLICY:** After filing with the insurance company on file, we will promptly mail you a patient statement. Payment in full is due upon receipt of this statement and is a courtesy from our office. If you have any questions or dispute the balance, it is your responsibility to contact our billing office within 30 days. Accounts past 30 days will be considered past due and will be subject to a 5% monthly late fee (minimum of $5.00 per month) and may be referred to a collection agency. If you are unable to pay the balance due in full, you must contact our billing office to discuss a payment schedule or arrangements. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements.

Patient Name:_____Date: _____

Parent/Guardian Name: _____

Patient Signature:_____(Parent/Guardian if minor)