Financial Responsibility

Copayments _____ (Initial)
All office visits require a copayment from your insurance company. Exceptions may include post operative visits for a determined period of time for some surgical procedures. Some insurance plans require co-payments for post operative visits.

Deductible _____ (Initial)
A deductible is a portion of the bill that is the responsibility of the patient to pay before an insurance company will cover the service. An office visit with our physicians will include a face-to-face encounter and evaluation. Generally, a copayment is required for the visit. In addition, some services and all procedures performed in the office require the patient to meet their deductible before insurance pays benefits. If you have not met your deductible, you will be responsible for full or partial payment, depending on your insurance contract. Procedures performed in the office are considered the same as surgery to the insurance company and are billed as surgery.

Diagnostic Procedure Consent ____ (Initial)
Your visit today may include a scope being place in your nose or throat. This is considered a diagnostic procedure, which will be coded to your insurance carrier as an **INVASIVE OR SURGICAL PROCEDURE**. Depending on the specifics of your particular policy, your insurance carrier will pay all, part, or none of the cost of this procedure. It is the responsibility of you, the insured, to be aware of the limits of coverage prior to this procedure. Any charges not covered by the insurance carrier will be the responsibility of the patient. **YOU HAVE THE RIGHT TO REFUSE THE DIAGNOSTIC PROCEDURE.**

No Show ____ (Initial)
Patients who fail to show for their scheduled appointment, procedure, or surgery or did not notify the office within 24 hours prior to the appointment, shall be subject a No Show penalty of $25.00 for missed appointments, $150.00 for office procedures, and $150.00 for surgery.

Guarantee of Payment for Services & Assignment of Benefits ____ (Initial)
It is the policy of the office that you must pay for services when rendered except in cases of surgery. If this applies to you, we will file your claim and you will be expected to pay only the portion that is not covered by your insurance. Please ask about this before leaving the office.

In the event that any of the above named companies or individuals fail to make prompt payment, I hereby give my personal guarantee of payment for all charges herein occurred. This includes all charges related to office visits, procedures performed, copayments and deductibles. If this account is placed in collections, the undersigned agrees to pay the balance plus a $25 surcharge for collections. I hereby authorize insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release my information in the processing of this claim.

Insurance Coverage ____ (Initial)
I understand that my eligibility for coverage by _____ has not been verified at the time of my appointment, but I want to receive medical services from Dr. _____.

I am aware that when the insurance is finally verified, there is a disclaimer which states my insurance does not guarantee payment, even though I may be eligible for benefits at the time of service. If it is determined that I am not eligible for coverage or the medical services are not covered, I understand that I will be responsible for payment for all services provided.

Referral Waiver ____ (Initial)
I understand that if the Referral from the Primary Care Physician's Office is not received before my appointment date, I agree to pay for all services rendered on the day of the visit

Administrative Fees _____ ACCEPT $20.00/calendar year (Initial) _____ DO NOT ACCEPT: will pay for services (Initials)

I understand the services listed below are included in the $20.00 administrative service fee one time per year. I am not required to pay the administrative fee; however, I understand that if I elect not to pay the administrative service fee, I will be responsible for the fees listed below: (**Records to the Primary Care/Referring Physician are FREE of charge and are not included in the $20.00 administrative fee**.)

Billable items on a requested basis-list include but are not limited to:

- $50.00 for completion of all forms including Disability, FMLA, Life Insurance or other miscellaneous administrative forms required by third parties other than your insurance company
- $15.00 for patient requested computer generated reports (additional claims, statements, payments histories, etc.)
- $38.00 for copying medical records
- Other administrative services that are not a covered service/benefit under your certificate of insurance. Fee to be determined at the time of request.

_____ _____

Signature (Guardian if patient is a minor) **Date**