PATIENT NAME:_____

Financial Responsibility

Co-payments _____ (Initial)

All office visits require a co-payment 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 co-payment 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 office visit today may include a scope being placed 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 of your policy prior to this procedure**. Any charges not covered by the insurance carrier will be the responsibility of the patient. By initialing this section you are acknowledging these terms. **YOU HAVE THE RIGHT TO REFUSE THE DIAGNOSTIC PROCEDURE.**

No Show _____ (Initial)

Patients who fail to show for their scheduled appointment, procedure, surgery, or did not notify the office within 24 HRS PRIOR to the appointment, shall be subject to a No Show penalty. These penalties are as follows: $25 for missed appointments, $150 for office procedures, and $150 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 the 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. If you have any questions, 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, co-payments 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 medical 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 my insurance requires a referral for my visit, I am responsible for making sure that the referral is obtained from my primary care physician. I also understand that if the referral from the primary care physician's office is not received before/on the day of my appointment, I agree to pay for all services rendered on the day of the visit.

Some offices offers the use of Care Credit for qualifying persons.

_____ _____

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