



PATIENT FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

We would like to thank you for choosing Ear, Nose, and Throat Specialists of Wisconsin as your medical provider. As one of our patients we would like to keep you informed of our current office and financial policies. We require a signature (black/blue ink only) prior to treatment. Please keep the copy provided for future reference.

Payment Methods: We accept **Visa, MasterCard, and Discover Card, check or cash.** In an attempt to reduce costly overhead we ask that payment be made at the time of service or in receipt of your statement after insurance has paid. Pursuing payment after we provide a service increases healthcare costs.

Insurance Claims: As a courtesy, we will file medical claims to your insurance company. Therefore, it is necessary to present ALL current insurance cards at the time of your appointment. We must be notified immediately of any changes; incorrect information delays payment and you will be responsible. As the insured, your coverage is based on the contract between you and your insurance carrier and ENT Specialists is not party to that contract. You must contact your health plan if you have not received notice of payment within 30 to 45 days of your service. Keep in touch; do not assume that they are “working on it.”

Patient Financial Responsibility: Your insurance may dictate that we collect co-payments, deductibles and coinsurance, which is not subject to discounts or adjustments. Appropriate adjustments will be made to your account should we hold a contract with your insurance company. You may also be responsible for 1) denied claims, 2) partial payments such as the health plan’s arbitrary determination of “usual and customary” rates, 3) and non-covered services.

Co-payments: Payment is due at the time of service at every appointment.

Uninsured: For uninsured patients, a payment of \$200 is required at the time of your first appointment. Please understand that this is a partial payment. Total charges cannot be determined until you have been examined; however, in addition to the office visit, there are additional costs associated with procedures and audiology services. Our Financial Counselor is available to assist you in making arrangements for your office visit(s). **We offer a 10% discount for payment in full at the time of service.**

Referrals: Many insurance companies will not pay for services rendered by a specialist without a referral. It is the responsibility of the patient/parent/legal guardian to obtain **any referral**, and updates, required by the health plan. Failure to provide a current referral may result in rescheduling the appointment until one is obtained.

Delinquent Accounts: All accounts must be satisfied within **60 days** unless arrangements have been made with our Financial Counselor. A prior arrangement for a regular scheduled payment plan is required; a partial payment for money due is unacceptable. If you have a financial hardship a copy of your most recent tax return is required. We may reschedule appointments or discontinue our relationship with you should bills go unpaid and no attempt has been made to reconcile the account.

Collection Accounts: If your account is referred to a third party for handling, a **\$25.00** service charge may be applied to your original balance.

NSF FEE: There is a **\$35.00** service charge for any returned check.

Supplemental Income/Disability Insurance Forms: There will be a charge of **\$25.00** for the completion of insurance disability forms. Payment is due at time of drop off or at time of pick up if faxed. Please allow 5 – 7 business days.

Minors: Minors under the age of 18 **must be accompanied** by a parent or court-appointed legal guardian for treatment. The accompanying parent or adult is responsible for payment. In divorce situations, please do not place our office in the middle of marital disputes. It is the responsibility between the custodial and non-custodial parent to work out payment arrangements of the child’s medical care.

Our Financial Counselor is available to answer any questions that you might have regarding billing or estimates.

I have read and agree to the terms of the policy and have received a copy of the Patient Financial Responsibility Acknowledgement. I hereby assign all medical and/or surgical benefits from _____ to Ear, Nose and Throat Specialists of Wisconsin, S.C. (Name of commercial/MediGap/Medicare replacement insurance company)

X _____
Signature of Responsible Party

X _____
Relationship to patient

X _____
Print Name of Responsible Party

Date

MEDICARE PATIENTS: We submit and accept assignment on all Medicare claims. As a courtesy, we will file to your secondary insurance. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Ear, Nose & Throat Specialists of WI, SC for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and I authorize release of medical information necessary to pay the claim. This authorization applies to all occasions of service and is in effect until I choose to revoke it.

Signed _____

Date _____