

Ear, Nose and Throat Specialists of Wisconsin, S.C.

FINANCIAL POLICY

*Thank you for choosing Ear, Nose, and Throat Specialists of Wisconsin for your ENT needs. We appreciate the opportunity to serve you and are committed to providing you with the best possible care. As part of our service to you, we try to contain the ever-rising cost of health care. In an effort to do this, we have implemented the following Financial Policy. Your cooperation in following our financial policy will allow for a prompt settlement of your claim. As a courtesy to you, we will file all medical claims, with the primary and secondary insurance. However, you must **provide** us with **current copies** of your insurance and notify us immediately when there are changes in this information. Please read and sign below (**black ink only**).*

- ÿ **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** required by the insurance company and update as needed. Failure to provide a current referral may result in rescheduling the appointment until one is obtained.
- ÿ **Co-payments:** If your insurance requires it (Medical Assistance included) co-payments are due at the time of service. We accept Visa and MasterCard. Check or exact change is appreciated.
- ÿ Appropriate adjustments to your account will be made should we hold a contract with your insurance company.
- ÿ Payment is due and payable in its entirety for co-payments, deductibles, co-insurance etc. at the time service is rendered, unless prior arrangements have been made with our billing office. Accounts must be satisfied within **90 days** or it may be referred to a collection agency unless the account is on a regular scheduled payment plan. If you have a financial hardship, documentation is required in order to make arrangements. We may reschedule appointments should bills go unpaid and no attempt has been made to reconcile the account.
- ÿ There is a **\$30.00** service charge for any returned check.
- ÿ Any questions regarding your insurance coverage, eligibility and benefits (payment) must be communicated by you directly with that company, as you hold the contract with that company, we do not. Check your policy for audiology/hearing aid coverage.
- ÿ **No Health Insurance Coverage:** **\$100.00** will be collected at the time of your first office visit to see the specialist. This does not include audiology services, in-office procedures or additional testing that the specialist may recommend.
- ÿ **Divorce:** In divorce situations, the parent who brought the child in is responsible for payment of the bill. We will submit to the necessary insurance carriers. **Both** parents will be billed for any outstanding balance.
- ÿ By law, all minors 18 years of age or younger, must be accompanied by a parent or court-appointed legal guardian in order for us to treat.

I have read and agree to the terms of the policy and have received/waived a copy of the Financial Policy. I hereby assign all medical and/or surgical benefits from _____ to Ear, Nose and Throat Specialists of Wisconsin, S.C. (Name of commercial/MediGap 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 _____