THE CENTERS FOR ADVANCED ENT CARE
CHESAPEAKE EAR, NOSE, AND THROAT

# Financial Policy

Thank you for choosing The Centers for Advanced ENT Care: Chesapeake Ear, Nose, and Throat LLC as your healthcare provider. We understand and realize the cost of healthcare is a concern for our patients and we are willing and available to discuss our fees with you at any time. Your clear understanding of our Financial Policy is important to our relationship. The following is information, which you must read, agree to, and sign prior to any services performed by our healthcare providers and support team. Carefully review the following and please ask if you have any questions about our fees, policies, or your responsibilities.

**PROVIDE ACCURATE INFORMATION:** As our patient, you have the responsibility to provide accurate and complete information about your health history, mailing address, health insurance coverage, and any other information needed for billing purposes. We require your insurance card and photo ID be scanned into our EMR system to verify in the event of claim errors. If any information changes (name, address, phone, insurance coverage etc.) you must inform this change to us immediately. Insurance denials and/or billing errors due to incorrect patient supplied information will result in the balance being the patient's financial responsibility.

**KNOW YOUR INSURANCE COVERAGE AND BENEFITS:** Your health insurance coverage is a contract between you and your health insurance carrier. You are responsible for understanding your health insurance coverage and benefits, not our staff. There may be limitations and exclusions to your coverage. You are responsible for any charges not covered by your plan.

**Insurance Use:** We require you to present your insurance card at every visit. The front office representative may not always ask for it, however, in the event the staff member does, you need to provide it. If you fail to provide us with the correct insurance information at any visit, as well as not providing the insurance card for scanning, a waiver will be required stating you will be responsible for payment of all services rendered and you will be responsible for submitting for reimbursement from your insurance carrier.

- Co-Payments are due at the time of services. This is a requirement placed by your insurance carrier. Please help us by knowing and paying your co-pay each visit.
- If your insurance company requires a referral, please bring a copy with you to your visit, as well as have one faxed to us at (410) 356-7806.You are responsible for obtaining a referral from your PCP.
- We will file claims to the insurance companies we contract with, provided that you authorize the assignment of benefits for payment direcetly to our practice. For plans that we participate in, the practice will accept payments based on contractual agreements. You agree to pay any portion of charges not covered by insurance.
- For insurance plans we do not contract with or accept, you will be responsible for all services rendered. We will give you the receipt for you to submit to your insurance for reimbursement.

- For Medicare and Medicaid insurance holders: We are not able to see any patients that have this insurance coverage as self-pay patients. No exceptions.

**SELF-PAY PATIENTS:** Self pay accounts are patients without insurance coverage or who are unable to provide us with valid insurance. You are responsible for paying 100% of charges and/or the down payment of $250.00 at the time the services are rendered.

**WORKERS COMPENSATION AND MOTOR VEHICLE ACCIDENT:** In the case of a worker's compensation injury, motor vehicle accident, and/or other third party liability, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier PRIOR to your visit. Failure to provide the above information may result in balances transferring to patient responsibility. Payment for any services that we provide will ultimately be patient responsibility if not paid by another party.

**BILLING STATEMENTS:** A statement will be sent to your address on file once a balance becomes patient responsibility and will continue every 30 days. Unless you notify our office that you dispute the validity of the balance or any portion thereof within 30 days, we will assume the balance is valid and correct.

**OUTSTANDING BALANCES AND COLLECTIONS:** All overdue balances shall be due within 14 days. The only exception is if payment arrangements have been made with a member of our billing department. After 90 days, you may be referred to our collection agency and will result in an alert placed on your account that must be paid before being seen for an appointment in the future. If the account is referred to an outside collection agency/attorney, the patient is responsible for paying any incurred fees.

**PAYMENTS:** Our practice gladly accepts Visa, Mastercard, American Express, Discover, Cash, and Check or money orders. If your check is returned for non-sufficient funds, you will be responsible for the return fee of $25.00.

**TREATMENT OF MINORS:** The parent(s) or legal guardian(s) is responsible for full payment and will receive the billing statements. A release will be required to treat unaccompanied minors.

**Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of service. Our office will not bill any other personal party.**

**AUTHORIZATION:** I have read, understand and agree to the financial policy stated above and accept responsibility for payment of all fees/charges incurred with The Centers for Advanced ENT Care: Chesapeake Ear, Nose, and Throat LLC.

_____ _____

Patient Printed Name Patient Date of Birth

_____ _____

Patient/Responsible Party Signature Date