BUCKS ENT ASSOCIATES FINANCIAL POLICY

NAME: ____ DOB: ____________________

Thank you for choosing Bucks E.N.T. Associates as your health care provider. We are committed to providing you with the best possible health care. The following information is provided to ensure you are aware of and understand our financial policy. Please ask if you have any questions about our fees and policies and your responsibilities. It is your responsibility to notify our office of any patient information changes (e.g. address, name change, insurance policy, etc).
PLEASE INITIAL ON EACH LINE AFTER READING EACH SECTION OF THE FINANCIAL POLICY:

_____ COPAYS, CO-INSURANCE, & DEDUCTIBLES
The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at the time of your appointment. We accept cash, checks, Visa, Mastercard, American Express, and Discover. If you have an insurance deductible or co-insurance, any and all office visit and/or procedure charges will apply towards your deductible, and you will be billed accordingly. If a patient is a minor (18 years of age and below) and is using a parent's insurance benefit, the parent or guardian must sign below. The parent or guardian assumes responsibility for any payment due at the time of service. If you are unable to pay for necessary medical care, you may be eligible for financial assistance or a payment plan. It is your responsibility to inform us of your financial need prior to your visit. Please ask to discuss arrangements with our billing department.

_____ MEDICAL PROCEDURES
Any medical procedures (e.g. treatment, laryngoscope or biopsies) performed in our office are considered separate, billable charges in addition to your office visit charge.

_____ COSMETIC FEES & PAYMENT
Certain procedures and services provided during your medical visit are not covered by most insurance companies. These are considered cosmetic procedures. It is your responsibility to understand that you may have cosmetic fees in addition to your medical visit. These fees are due at the time of service.

_____ INSURANCE CLAIMS
As a courtesy to you, we will submit medical claims to your insurance company. Any balance after processing of the claim by your carrier is your responsibility. Your insurance policy is a contract between you and your insurance company. You are responsible for verifying if providers are in network with your insurance company. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is your responsibility to know your insurance benefits as it may not cover all of the services provided to you. If your insurance requires referrals to specialists, it is your responsibility to obtain that referral PRIOR to your appointment. Failure to obtain a valid referral may hold you responsible for any payments incurred for services rendered. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered including, but not limited to, those charges above the usual and customary allowance. If we are out of network and your insurance pays you directly, you are responsible for payment in full and agree to forward the payment to us immediately.

_____ SELF-PAY ACCOUNTS
Self-pay accounts are patients without insurance coverage or patients covered by insurance plans in which the office does not participate. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay accounts are payable at the time of service.

_____ CANCELLATION OF APPOINTMENTS
Bucks E.N.T. Associates requires a 48-hour notice for appointment cancellations so that we can offer the appointment to another patient who needs to be seen. There is a fee of $25 for appointments that are missed and/or are not previously cancelled and a fee of $50 for any office procedure appointment (including E.N.G's, myringotomy, excisions, etc.). This fee must be paid before rescheduling the missed appointment. Any Hearing Impaired arrangements with our contracted interpreter requires more than 48 hours notice due to their surcharge for cancelling which is $150, this fee will be billed to the patient. After five missed appointments it will be at our discretion to dismiss the patient from the practice.

_____ RETURNED CHECKS
The charge for returned checks is $30 payable in cash or by credit card. This will be applied to your account in addition to the insufficient funds amount.

_____ OUTSTANDING BALANCE POLICY
A medical practice, like any business, depends on timely payments. It is our policy that all accounts remain current. In the event that a patient balance remains outstanding and no resolution can be made, your account may be sent to a collection agency and/or you may be discharged from the practice.

_____ LABORATORY FEES
Most laboratory charges, such as blood work, cultures, and pathology tests, ordered through our office are billed directly to your insurance by the laboratory processing the test. If you receive a statement from the pathologist laboratory, we request that you contact them directly to resolve any billing questions.

_____ ASSIGNMENT OF BENEFITS
I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan to issue payment directly to Bucks E.N.T. Associates. I understand that I am responsible for any amount not covered by insurance. I have read and understand the above information and agree to comply with these financial policies.
____ Printed Name of Patient or Legal Guardian ____ Patient Name (If different from above) _______________________ Date _______________________ Date
____ _______________________
Signature of Patient or Legal Guardian Date Rev. 05/20