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Ear, Nose & Throat/Facial Cosmetic Surgery
Allergy Testing & Treatment
Audiology/Hearing Aids

HEAD AND NECK SURGICAL ASSOCIATES

PAYMENT POLICY

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality and affordable health care.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we are contracted with, payment for your services is expected at your visit. If you are insured by a plan with which we are contracted but, do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your current coverage. Knowledge of your insurance benefits and eligibility is patient responsibility. Please contact your insurance company with any questions you may have regarding your coverage. ______ (initial)

CO-PAYMENTS AND DEDUCTIBLES: All co-payments and deductible/co-insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductible from the patient can be considered fraud. Please help us in upholding the law by paying your co-pays at each visit.
______ (initial)

NON-COVERED SERVICES: Please be aware that some (and perhaps all) services provided may be, as described by your insurance company, non-covered or not considered reasonable or necessary by policy standards. You must pay for these services in full at the time of visit.
______ (initial)

PROOF OF INSURANCE: All patients must complete our patient information form before seeing the providers. We must obtain a copy of your driver's license and valid insurance cards. If you fail to provide us with this information at the time of visit, you will be considered responsible for the balance. ______ (initial)

CLAIMS SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply additional information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays. Your insurance policy is a contract between you and your insurance company; we are not party to that contract. ______ (initial)

(continued on reverse)

COVERAGE CHANGES: If your insurance changes, please notify us so we can make the appropriate changes to help you receive your maximum benefits. _____ (initial)

FORMS: If a specific form needs to be completed, there may be a $30.00 fee due and payable before the form is completed (i.e. FMLA). _____ (initial)

MISSED APPOINTMENTS: Please help us serve you better by keeping your regularly scheduled appointment. To avoid a $25.00 cancellation fee, please give us 24 hours advance notice when cancelling appointments. _____ (initial)

NON-PAYMENT: Please be aware that if a past due balance remains unpaid; we may refer your account to a collection agency. _____ (initial)

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINES.

_______________________________________ _______________________

Signature of patient or responsible party Date

I authorize Head & Neck Surgical Associates to contact me via current and any future cellular phone number(s), email address, or wireless device(s) regarding my delinquent accounts(s) I owe to Head & Neck Surgical Associates. I authorize and its agents, representatives, and attorneys (including collection agencies) to use automated telephone dialing equipment, artificial or pre-recorded voice or text messages and personal calls and emails, in their effort to contact me for purposes of collecting any portion of my account which is past due.

I/We have read this disclosure and agree to the terms of the described above.

_______________________________________ _______________________

NAME Date

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of any medical information needed to process a claim. I also authorize the release of medical benefits directly to the physician for services described.

I hereby authorize Head and Neck Surgical Associates to furnish medical information pertinent to my medical condition including, but not limited to the diagnosis, treatment and care offered or rendered to me in regards to referrals, hospitalization and/or further testing.

By signing this Consent to Release Medical Information, I agree not to hold Head and Neck Surgical Associates, its agents and/or employees, liable for any unfavorable outcomes as a result of releasing this information. I understand I can revoke this authorization at any time, (in writing).

_______________________________________ _______________________

Signature of patient or responsible party Date

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PRINT Patient Name

Revised 8/24/16