

Alamance ENT and Facial Plastic Surgery Financial Policy and Payment Agreement

Alamance Ear, Nose and Throat & Facial Plastic Surgery is committed to providing you with the best possible care. If you have medical insurance we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals, however, we need your assistance and your understanding of our financial payment policy.

I. Financial Policy.

- a. Self-pay patients are expected to pay for services received in full at the time of service. Any financial arrangements must be made before you see the physician. We accept the following forms of payment: cash, check, American Express, MasterCard, Visa, and Discover.
- b. As a courtesy to you, we will file your insurance claim form for reimbursement. However, in order to do this, we must have current insurance information for each visit. Charges not paid by your insurance company within 90 days will become due and payable by you. Patients who do not provide current insurance information will be treated as self pay (see above).
- c. If your insurance plan requires a referral or authorization from your primary care physician, we will need to receive the authorization before you see our physician. If you have not received an authorization prior to your arrival at our office, we have a telephone available for you to call your primary care physician or insurance company to get the required authorization. If you are unable to obtain the authorization, you can sign a medical waiver and pay us directly for the services we provide you, and we will refund you when we receive the proper authorization for those services.
- d. Surgical procedures may require a deposit, including deductibles, co-payments and coinsurance. Payment of these amounts is required before the procedure is performed.
- e. Parents, a designated family member, or legal guardian are responsible for payment for services rendered to children. The responsibility for payment of services rendered to dependent children whose parents are divorced rests with the parent seeking treatment. Any court ordered responsibility judgment must be determined between the individuals involved and cannot be considered by this office.
- f. In the event your insurance company determines a service to be “not covered,” you will be responsible for payment. We try to inform patients when services may not be covered; however, it is the patient’s responsibility to understand their health insurance limitations.

- g. In order for us to accept and file Medicaid we must have a CURRENT Medicaid card on file for each visit. Carolina Access requires an authorization from your primary care physician. Without this information you will be considered self-pay and Medicaid will allow us to collect from you at the time services are provided.
- h. We will bill for Workers' Compensation services that have been pre-authorized by your employer or Workers' Compensation insurance carrier.
- i. **Returned Check Fee:** A \$25.00 service charge will be applied to your account for any returned check. If a check is returned, we will only accept cash or a credit card as payment on your account.
- j. **Appointment No-Show Fee:** We understand that sometimes appointments must either be cancelled or rescheduled. Because we provide specialized services, we ask that you provide at least a 24 hour prior notice for cancellations or rescheduled appointments. Your failure to provide us the requested 24 hour notice will result in a no-show fee of \$50.00.
- k. **Prescription Refill Fee:** If approved by a physician during a scheduled office visit, we will be happy to refill any previously prescribed medication ordered by our practice. Should a refill request of a previously prescribed medication ordered by one of our physicians be received from any source (you, your pharmacy, or otherwise) at a time other than a scheduled office visit, a \$10.00 refill fee will be charged to your account for each prescription refilled.
- l. **Statement Billing Fee:** If the balance due shown on account statements is not paid in full or if no payment is received, we will add a \$2.50 statement billing fee to all second and subsequent statements to cover handling and mailing costs.
- m. **Additional Fees:** We charge additional fees as outlined below:
- A \$50.00 no-show fee should you fail to notify us at least 24 hours in advance for scheduled Allergy testing and instruction.
 - A \$25.00 fee for completion of Disability Forms.
 - A \$25.00 fee for completion for the Family Medical Leave Act (FLMA) Form.
- n. **Please be aware that any balance on your account over 90 days is subject to intensive collection procedures and may result in denial of future care until overdue balances are paid in full.**

II. Payment Agreement.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account. I accept full responsibility for any and all charges related to diagnosis and treatment, whether or not my insurance covers these services. I agree to pay IN FULL within 30 days of receipt of notice all balances due such as non-covered services, coinsurances, deductibles and co-payments not paid by my insurance company in addition to any fees charged against my account.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, OR HAS BEEN READ, THE FOREGOING; UNDERSTANDS THE FOREGOING; HAS RECEIVED A COPY THEREOF; HAS BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS THEY MAY HAVE CONCERNING THE FOREGOING; AND THAT HE/SHE IS THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE OF THE PATIENT. THE UNDERSIGNED, HAVING READ AND UNDERSTOOD THE AGREEMENT, ACCEPTS THIS FINANCIAL POLICY AND PAYMENT AGREEMENT.

Patient Name (Please Print)

Patient's Signature

Date

Responsible/Authorized Representative (Guarantor)

Relationship to Patient

Guarantor Signature

Date