CLEVELAND EAR NOSE THROAT INC. - FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to providing quality medical care. Please understand that payment of your bill is considered part of your care plan. We ask that you read and sign this Financial Policy prior to any treatment. Please let us know if you have any questions.

- ***We will attempt to verify your insurance coverage at every visit. It is the patient's responsibility to supply all current insurance cards. If you have given us an outdated insurance card and payment is denied for any reason, you will be responsible for payment of the denied charges.***
- We will copy your driver's license or picture identification issued from DMV for identity verification.
- If you do not have insurance, or cannot provide proof of insurance at the time of service, a pre-payment (or deposit) will be required before services are provided, except in the case of an emergency.
- Co-pays are due at time of service. If you have a high deductible insurance plan, a pre-payment or deposit may be required.
- If your insurance requires a referral from your Primary Care Provider (PCP) to see another physician, it is your responsibility to obtain a referral/authorization prior to your appointment. Any unauthorized services may be your responsibility.
- The accompanying parent/guardian of a minor to a visit is responsible for payment if requested. We cannot be involved in negotiating between parents in custody disputes.
- When labs, x-rays, MRIs or other tests are ordered, you are responsible to check with your insurance company as to where you are authorized to have these services performed. We will not be responsible for any bill if you have these services provided at an out of network location.

As a courtesy to our patients, we will submit claims to your insurance carrier(s) for you. Insurance plans vary considerably, and we cannot guarantee or predict what part of your services will or will not be covered by a particular plan. The patient is responsible to know the rules of their health plan, as we cannot change our coding or billing in an attempt to obtain payment.

I have read and understand Cleveland Ear Nose Throat Inc.'s financial policy, and I agree to the terms. I also understand and agree that the practice may modify or amend terms from time to time.

_____ _____ _____

(Printed name of patient) (Signature of patient or guardian) (Date)

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Cleveland Ear Nose Throat Inc. for any services furnished to me by their providers. I authorize release to the Centers for Medicare & Medicaid Services and its agents any medical information about me needed to determine the benefits payable for related services.

_____

(Signature of patient or guardian)

Assignment and Release (All other payers)

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Cleveland Ear Nose Throat Inc. all insurance benefits otherwise payable to me for services rendered. I hereby authorize the provider to release all information necessary to secure the payment of benefits.

_____

(Signature of patient or guardian)

Acknowledgment of Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You may review our notice, which is displayed in the Waiting Room and available from your Front Desk Staff.

I have read the Notice of Privacy Practices and/or I have been provided an opportunity to review it.

_____

(Signature of patient or guardian)