AFFILIATED EAR, NOSE & THROAT PHYSICIANS

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APPOINTMENT POLICY: If you have a change in plans and will not be able to keep your scheduled appointment, you must contact us to cancel. This will allow us to give your appointment time to another patient. A $20.00 charge may be made to your account if you fail to cancel your appointment.

FINANCIAL POLICY: To help us provide the most efficient and reasonable health care services, it is necessary for us to have a financial policy stating our requirements for payment of services provided to patients.

Patients are responsible for the payment of all services provided by Affiliated Ear, Nose and Throat Physicians. You will be asked to pay any co-pay, deductible, or co-insurance that is patient responsibility at the time of your visit. We accept personal checks, Visa, MasterCard, Discover and debit cards. It is our policy to file your insurance as a courtesy to you if we have accurate and complete insurance information. The balance due is still your responsibility if we have not received payment from the insurance carrier within 45 days of the date of service. There will be a $30.00 service fee added to your account for any check returned unpaid from the bank for any reason.

If you do not have any insurance, you will be considered "self-pay" and payment is due **IN FULL** at the time of service.

If you have insurance, and you have asked us to file a claim for you, we ask that you pay, at the time of service, your co-pay, co-insurance, any deductible not met or any portion which would be your responsibility. If you are covered under an **HMO**, you are responsible for obtaining all referrals necessary for payment from your primary care physician.

Medicare Beneficiaries – CT scans are performed in our facility. If desired, these CT scans may be performed at: Centegra MMC-Woodstock; Centegra NIMC-McHenry; Mercy-Woodstock; Good Shepherd Hospital-Barrington or Sherman Hospital-Elgin. Addresses available upon request.

Our financial policy is necessary to assure the financial resources needed to maintain vital health care for all our patients, as well as ensure that we will be reimbursed for your care on a timely basis. We welcome the opportunity to discuss any aspect of our financial policy.

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- **Assignment of Insurance Benefits**: I hereby authorize direct payment of benefits to Affiliated ENT Physicians for services rendered.
- **Authorization for Release of Information**: I hereby authorize Affiliated ENT Physicians to release any medical information necessary for the processing of my insurance claim if requested by my insurance company.

I have read the Financial Policy and Appointment Policy of Affiliated ENT Physicians and hereby agree to abide by the provisions it sets forth.

I understand that there will be an $18.00 per month rebilling fee assessed to my account for any "patient responsibility balance" not paid after 60 days.

I further understand that I will be responsible for any charges incurred in the collection of my account, which may include an additional 30% collection fee added to my outstanding balance, attorney fees and court costs, should it become necessary to refer my bill to a collection agency.

**For informational purposes only. Information subject to change. Policy will be signed at scheduled appointment.