FINANCIAL POLICY STATEMENT AND AGREEMENT

We will gladly discuss your proposed treatment and answer any questions related to your health insurance coverage to the best of our ability.

We prefer payment for services by cash and checks, but will accept VISA or MasterCard.

Please note that we may be "participating providers" with your insurance carrier. However, you are still responsible for all copayments and deductibles at the time services are rendered.

I understand that:

- Health insurance is a contract of my choice between me and my insurance carrier.
- Not all services are covered benefits in all contracts. Some insurance carriers select certain services they will not cover.
- We will not bill you for copays. They are due at the time services are rendered.
- A billing fee of $10.00 is assessed for each statement mailed to me after my insurance carrier pays and one statement is mailed to me. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.
- **All accounts over 90 days are turned over to our collection service for payment**. In the event that my account is turned over for collection, I will be responsible for all collection service fees, interest, and all legal fees associated with collecting my account. All accounts turned over to our collection service must be settled prior to making another appointment.
- I will be billed $50 each appointment not cancelled 24 hours before your scheduled appointment time. This is a non-refundable charge, may not be applied to any other patient responsibility and must be paid prior to making another appointment.
- I will be charged a fee of $.50 per sheet for copying all medical records and I may also be responsible for any potage costs, if necessary.
- I will be charged a fee of $15.00 for completion of each set of FMLA Forms.

I further understand that I am ultimately responsible for the balance on my account for any professional services rendered.

I authorize the release of any medical or other information necessary to process my insurance claim. I also authorize payments under my insurance programs to be made directly to Meadowcrest ENT for any medical services rendered.

I further permit copies of this authorization to be used in place of the original.

_____ _____

Patient Printed Name (Or Responsible Party) Date

_____

Patient Signature (Or Responsible Party)

11/2015