ENT Associates of Central PA, PC

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PATIENT FINANCIAL RESPONSIBILITY POLICY AND DISCLOSURE STATEMENT

Your signature below forms a binding agreement between ENT Associates of Central PA, PC (the provider of medical services) and the Patient who is receiving medical services or the Responsible Party for minor patients (patient under age 18).The Responsible Party is the individual who is financially responsible for payment of all medical bills.

All charges for services rendered are due and payable at the time of service. We have contracts with many insurance companies, and we will bill them as a service to you. As the Responsible Party, you are responsible for all payments if your insurance company declines to pay for any reason.

The Patient and/or the Responsible Party:

- MUST, at each office visit, inform ENT Associates of Central PA, PC (ENTACPA) of the current address and telephone number for both the Patient and the Responsible Party
- MUST present all current insurance cards prior to each office visit
- MUST verify, at each visit, the name of your family physician and all other demographic information
- MUST comply with the payment policy requirements outlined in PATIENT PAYMENT POLICY **(Please see Patient Payment Policy, Effective August 1, 2014)**
- MUST agree to pay a $35.00 fee for checks returned for insufficient funds

NOTE:

It is important to note that patients often require additional testing or surgical procedures including, but not limited to, endoscopy, laryngoscopy, and tubes. As per the *National Correct Coding Initiative*, and our contracts with insurers, we are required to submit a bill for these services **SEPARATE** from the office visit fee. The fees for these procedures are in **ADDITION** to the co-pay for the office visit. The Patient or the Responsible Party is responsible for the payment of these additional fees.

We require a credit card to secure payments for any unknown balance that your insurance company may not cover. Once ENTACPA receives an Explanation of Benefits (EOB) from your insurance, we will charge your credit care if there is any outstanding balance that is owed. **Your signature on this form is your authorization to process payments to the credit card you provided. Balances greater than $300 patient will be charged a minimum payment of $100 per month until paid in full.**

Non-Payment of Account:

All account balances must be paid, in full. **Should collection proceedings become necessary to collect balances on overdue accounts, The Patient will be terminated from the Practice**. ENTACPA has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The Patient, or the Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, all court costs, attorney fees, and collection fees, if assessed to the outstanding balance.

As the Patient or the Responsible Party, your signature indicates that you have read, understand and accept the terms and conditions in the Patient Financial Responsibility Policy and Disclosure Statement.

Print Patient's Name: _____

Patient's Signature: _____ Date_____

Print Responsible Party's Name: _____

Responsible Party's Signature: _____ Date_____