



## Financial Policy Statement

Dear Patient,

Thank you for selecting the services of Ear, Nose, & Throat Physicians & Surgeons, P.A. for your medical needs. In an effort to make your contact with us as professional and pleasant as possible, and to continue to provide quality care at reasonable costs, we ask that you be aware of the following office policies:

- 1. All charges you incur are your responsibility regardless of your insurance coverage. As your ENT specialist, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer and the insurance company. Our practice is not a party to that contract. If payment from your insurance company is not received within sixty days from the date of service, you will be expected to pay the balance in full.**
2. Please bring your insurance card with you to the appointment so that we may photocopy it or scan it for our records. If you have an insurance plan that we participate with, and have the appropriate referral, we will require only your co-payment amount at check-in. Payments may be made in the form of cash, check, Visa, MasterCard or debit card.
3. As a courtesy, we will submit claim forms to your insurance company if you have provided us with the correct billing information including the current insurance card. **Please remember if your plan requires referrals, it is your responsibility to organize this prior to your appointment with the specialist. If you do not have a referral, you must sign a waiver that you are responsible for the full fee whether your insurance pays or not.**
4. If at your visit, there is no proof of insurance, you will be required to make payment in the amount of \$200.00 prior to seeing the provider. If the cost of the services is less than \$200.00, you will be refunded the difference. If the cost of the service is greater than \$200.00, you will be billed the remainder. You can set up an auto-pay plan with our billing department.
5. Please plan to arrive 15 minutes prior to your appointment. We need to update your information, including address, insurance, phone numbers and current medications before you see the provider. In the event that your provider is delayed, we will make every effort to contact you should it be necessary or desirable to reschedule your appointment.
6. Please call to cancel any appointment you are unable to keep it. **We reserve the right to charge a \$25.00 service fee if you do not notify us at least twenty-four hours in advance that you will not be keeping your appointment.**
7. If you are an established patient with past due self-pay balances, you will be required to make payment in full prior to seeing the provider.

8. If there are extenuating circumstances, payment plan arrangements can be made prior to your visit by contacting our office at 595-4800 x 116 (Nashua) or 669-0831 x 29 (Manchester).
9. If any payment is made by your insurance company to us in excess of the balance, we will promptly refund you or the insurance company as appropriate.
10. These procedures will be billed separately in addition to office visit charges. Some insurance carriers classify these procedures as "Surgery" and may apply the charges to a higher deductible or co-insurance amount depending on your insurance plan. The result may be an insurance payment for an office visit but not for the procedure due to deductible balance or co-insurance. In such cases, payment for the procedure will be due from the patient. Be assured that we are following accepted billing and coding guidelines and that the procedures are performed in the best interest of patient care.

Should you have any questions regarding our policies, please feel free to inquire with your physician or any staff member. Thank you for the opportunity to be of service.

I have read and understood the financial policy explained above.

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Patient Name (print) \_\_\_\_\_ Date \_\_\_\_\_

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Patient/Guardian Signature \_\_\_\_\_ Printed name of Patient or Guardian \_\_\_\_\_

### **HIPAA Privacy Policy**

A copy of the Privacy Policy is available at the front desk for your review. You are welcome to take it home with you at any visit or you may download a copy from our website at [www.ent-phys.com](http://www.ent-phys.com).

I have been offered a copy of the privacy policy.

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Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_