Connecticut Ear, Nose & Throat Associates

Financial & Office Policies

Thank you for choosing us as your healthcare provider. We care about our patient's physical and financial well being and welcome the opportunity to work with you on any billing issue that may arise. We have implemented a new financial and office policy stating our expectations and options for payment.

Registration & Check-In

I understand that copays and past due balances are due at the time of check-in and I will come prepared to pay or be charged an **additional $10 for processing**. I will also bring my current insurance card and driver's license to each visit to ensure my claims are sent to the appropriate insurance company and to protect my identity. I understand that if I arrive 15 minutes late for my appointment, I may be asked to reschedule so that other patients are not inconvenienced. **I also understand that I will be charged a fee of $50 if I no show for my appointment ($75 for an office procedure) or cancel without giving 24 hours notice. I understand that two no-show appointments may result in my discharge from the practice. (Discharge from the practice is done at the discretion of the treating physician)**

Insurance Billing

Though Connecticut Ear Nose & Throat Assoc., P.C. accepts most insurance plans; I understand that it is my responsibility to confirm with my insurance company that the physician is currently under contract. I agree to be responsible for all copays, deductibles and non-covered services determined by my insurance plan.

Insurance Referrals

If my insurance plan requires a referral to a specialist, I understand that I must obtain that referral prior to my scheduled visit. If the referral is not obtained, I understand that I have the option of rescheduling my appointment or paying for the visit out of pocket.

Self Pay

If I am un-insured or do not have proof of insurance, I understand that full payment is expected at the time of service unless prior arrangements have been made.

Patient Billing

I understand that I will be sent a **single** monthly statement followed by a reminder letter for services received. I will promptly pay all amounts determined to be my responsibility by my insurance carrier upon receipt of my statement. I give Connecticut Ear, Nose and Throat expressed written consent to place telephone calls to my home or cell phone in attempts to collect any outstanding balance(s). **If my account is not paid within 90 days of the date of service, the practice may ask for the assistance of an outside collections attorney. If my account is referred to a collections attorney, I may be dismissed from the practice and will be responsible for any reasonable cost of collection including credit checks, court costs and attorney's fees.** If I have any questions regarding my bill or have a financial hardship, I will call the office to make other arrangements. I understand that if my check is returned, I will be charged a fee of $25.00.

Surgical and Office Procedures

I understand that my insurance company may not cover the entire cost of procedures rendered in the office or in the operating room. **Some insurances companies apply an additional copay to hearing tests.** If it is determined that there will be a significant out of pocket expense for my procedure, I understand that I will be asked to either make a prepayment or schedule of payments using Connecticut Ear Nose & Throat Assoc., P.C.'s *card on file* system. I understand that my credit card or checking information will be secured by the office.

I have read, understood and agree to abide by the terms stated in the above financial and office policy.

Name_____ Patient (or Parent/Guardian) Signature _____

Date_____