

***Patient Financial Agreement
&
Acknowledgement of Receipt of the Notice of Privacy Practices***

Patient Name & Date of Birth (please print): _____

Thank you for choosing ENT Associates. In addition to providing you high quality medical care, we also feel it is very important to provide you with helpful financial information as outlined below and courteous staff to help answer any questions you may have.

Fees Information

- Fees are determined by the degree of complexity, as well as the skill and time required for each visit or procedure.
- **Endoscopy and other office procedures, when performed are billed separately from your office visit.**
- We comply with Wisconsin Act 146 and provide certain charge information upon request.

Insurance Coverage

- It is your responsibility to provide us with complete and accurate insurance coverage information, as we bill your insurance as a courtesy to you.
- If accurate and complete information isn't provided before or at the time of service, you are responsible for the full balance.
- If your insurance coverage requires a co-pay, we will collect that co-pay at the time of service.
- It is your responsibility to understand your insurance benefits. We know this can be very confusing and we are here to help. We will verify benefits prior to higher cost procedures and if you need help communicating with your insurance company, we will be happy to assist you.
- Certain procedures will not be scheduled until insurance coverage has been verified, so that you are informed as to what your financial responsibility will be.
- Since you are covered under an insurance contract we are often unable to provide additional discounts.
- If you are not able to pay your balance in full, we do offer payment plans. Depending on your balance, we can make arrangements for 3 to 12 months.

No Insurance Coverage

- Any outstanding balances must be paid in full prior to scheduling.
- A \$100 down payment will be required at the time of scheduling and will be applied to charges related to your visit.
- We will provide you with a 20% discount off our established fees.
- If you are not able to pay your balance in full, we do offer payment plans. Depending on your balance, we can make arrangements for 3 to 12 months.
- **The above discounts and payment arrangements do not apply to hearing aid sales, services or supplies.**

Surgeries and Procedures

- A partial payment prior to service will be required. Our insurance department will work with you on this.

Collection Accounts

- If we are unable to work with you to pay your balance and your payments default, we will turn your account over to collections agency. If this happens, your balance must be paid in full before further care can be provided.

Non-Sufficient Funds (NSF):

- **Check Policy - *By using a check for payment, you agree to the following terms:*** In the event your check is dishonored or returned for any reason, you authorize us to electronically (or by paper draft) re-present the check to your bank account for collection of the amount of the check, plus any applicable fees as permitted by state law.

Re\$ubmitIt

Please Print name of person financially responsible for this patient (Guarantor) _____

Guarantor Signature _____ Date _____

DIVORCED / SEPARATED PARENTS:

In an effort to clarify how the financial responsibility works in this situation, our policy is that the parent presenting with the dependent is **responsible for all charges**. If the divorce decree indicates otherwise, the legally responsible parent must sign.

Please sign in the space provided, recognizing having read and understood our Patient Financial Policy. Should you have any questions or concerns, please let us know and we will be pleased to assist you.

Please Print name of parent presenting the dependent _____

Signature of Presenting Parent _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

In accordance with HIPAA (Health Insurance Portability & Accountability Act), I have been provided and/or offered a copy of the Ear, Nose and Throat Associates Privacy Notice. I understand the notice may also be found on their website at www.entwausau.com

Signature _____ Date _____