ALPINE
EAR, NOSE & THROAT, P.C.

FINANCIAL POLICY

Welcome to Alpine Ear, Nose & Throat. Please take a few minutes to review the following information prior to your appointment.

We hope you understand that our financial policies are established to assure the financial resources needed to maintain this medical office for all our patients. We will work with you to ensure that your medical care does not become a financial burden.

- Charges for medical services are due and payable at the time of service. We accept cash, personal checks, and visa and master card credit cards for payment of your account.

- Your insurance policy is an agreement between you and your insurance company. Our relationship is with you, and not with your insurance company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status.

- **IT IS THE PATIENT'S RESPONSIBILITY TO KNOW THEIR BENEFITS.YOUR POLICY MAY APPLY ALLERGY TESTING/INJECTIONS, AUDIO TESTS, CONSULTATIONS, PHYSICAL THERAPY AND SCOPES (including postoperative scopes) TOWARDS YOUR DEDUCTIBLE; THEREFORE, IF YOU HAVE QUESTIONS REGARDING YOUR BENEFITS, IT IS IN YOUR BEST INTEREST TO CONTACT YOUR CARRIER DIRECTLY. INITIAL_____**

- **OFFICE VISITS REQUIRE A 24-HOUR CANCELLATION NOTICE.**
- **PATIENTS WILL BE CHARGED A $25 FEE FOR NOT GIVING NOTICE.**
- **TESTS REQUIRE A 48-HOUR CANCELLATION NOTICE; PATIENTS WILL BE CHARGED A $75 FEE FOR NOT GIVING NOTICE.**
- **SURGERY CANCELLATIONS REQUIRE A 3-DAY NOTICE. PATIENTS WILL BE CHARGED $250 FOR NOT GIVING PROPER NOTICE.**

If you have health insurance with which we participate:
- **We will bill your insurance claim for you**
- **We expect any required co-payments or deductibles due at time of service**

If we do not participate with your insurance plan:
- **Payment is due at time of service and filing your claim is your responsibility**

NOTE: If surgery is necessary, we will file your insurance claims as a courtesy to you

Accounts 30 days past due are subject to collection proceedings except when prior arrangements have been made with our business office. Please sign and date this form. Return to the Receptionist and she will provide you with a copy for your records.

I authorize Alpine Ear, Nose & Throat to furnish diagnosis and records of any treatment or examination rendered to me or my child during the period of such care to any or all of the following: Physicians involved in my treatment, Medicare, my insurance carrier (s), or my employer (for work related injuries).

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that Alpine charges a $5.00/month statement fee for any balances that are not paid in full. I understand that if my co-payment is not made at time of service there will be a $10.00 late fee for non payment.

I authorize Alpine Ear, Nose & Throat to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I hereby expressly agrees and consents to Alpine ENT, their employees, agents, collections agents, service providers and the like to contact me using any contact information that I or my representative provide to any Provider (s), including mail, email, phone call or text message (further including contacts via wireless telephone numbers or other numbers which may result in charges to me). I expressly consent to Provider(s) contacting me on this telephone number regarding my hospitalization, my appointments, medical services rendered or to be provided, my financial obligations, financial assistance for my account(s), debt collection related to my account(s), or any matter relating to my medical care. I understand that the methods of contact may include pre-recorded or artificial voice messages and/or automatic telephone dialing or texting systems.

I have read and understand the above statement:
DATE:_____Signature:_____
Print Name:_____Witness:_____