ALPINE
EAR, NOSE & THROAT, P.C.

Financial Policy

Please take a few moments to review the following information prior to your appointment.

- Charges for medical services are due and payable at the time of service. We accept cash, personal check, and credit cards (Visa, MasterCard, and Discover) for payment of your account.
- Your insurance policy is an agreement between you and 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 INSURANCE CARRIER DIRECTLY.**
  INITIAL: _____

If you have health insurance with which we participate:

- We will bill your insurance claim for you
- We expect any required co-payments, co-insurance, or deductibles due at time of service

If we do not participate with your insurance plan:

- Payment is due at the time of service and filing your claim is your responsibility

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

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

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.

I authorize Alpine ENT 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(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 the time of service there will be a $10.00 late fee for non-payment.

I authorize Alpine ENT to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I hereby expressly agree and consent to Alpine ENT, their employees, agents, collection 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, or by phone. I expressly consent to Provider(s) contacting me 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 messages and/or automatic telephone dialing or texting services.

_____ _____
Print Name Date

_____ _____
Signature Alpine Witness