

**FINANCIAL POLICY**

Thank you for choosing us as your health care provider. We are committed to providing quality medical care. Please understand that payment of your bill is considered part of your care plan. We ask that you read and sign this Financial Policy prior to any treatment. Please let us know if you have any questions.

- We will verify with you your insurance coverage at every visit. It is the patient's responsibility to supply all current insurance cards.
- We will ask you for a copy of your driver's license or other picture identification issued from DMV for identity verification.
- If you do not have insurance, or cannot provide proof of insurance at the time of service, a pre-payment of \$75.00 will be required before services are provided except in the case of emergency.
- A \$5.00 fee will be assessed for any co-payments not made at the time of service. We also charge a \$10.00 fee for re-billing insurance and/or billing insurance not provided to us at the time of service.
- We accept cash, checks, Visa, MasterCard, Discover, and American Express. A \$25.00 fee will be assessed for any returned checks.
- Payment plans can be arranged with the billing office. Any accounts over 90 days old will receive a \$5.00 billing fee per month until the account is paid in full.
- If your insurance company requires a referral from your Primary Care Physician (PCP) to see a specialist, it is your responsibility to obtain a referral/authorization prior to your appointment. **ANY UNAUTHORIZED CHARGES WILL BE YOUR RESPONSIBILITY.**
- The adult accompanying a minor to a visit and the legal parents/guardians are responsible for full payment. We will not be involved in negotiating between parents in custody disputes.
- As a specialty office it is necessary for us to perform diagnostic services such as scopes, hearing tests, and CT scans in order to provide you with the highest quality of ENT care. There is a separate charge for each of these services and all insurances can cover them differently. We highly recommend that you contact your insurance carrier with any questions that you may have regarding your coverage for these services.

As a courtesy to our patients, we will submit claims to your insurance carrier for you. For those plans that we participate in, we will also submit secondary and/or tertiary claims. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered by your plan, or how it will be covered by your plan. The patient is responsible for knowing the details/rules of their health plan(s), as we cannot change our coding in an attempt to obtain payment.

I hereby authorize Willamette ENT, LLP to release any medical information required in the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes, but is not limited to, co-payment, co-insurance, deductible, and non-covered services.

I have read, understood and agree to the Financial Policy (above)

\_\_\_\_\_  
Name Of Patient or Responsible Party (Please Print)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I received the Notice of Privacy Practices for Willamette Ear, Nose, Throat and FPS, LLP

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date