Ear, Nose, & Throat Consultants, Inc.

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Billing Policy

Patient Name:_____ Chart # _____ (staff to complete)

Referrals, co-payments and deductibles for services rendered are your responsibility. Office procedures may be required to provide you appropriate care. Procedures might include nasal endoscopy, excision of lesions, biopsies, removal of impacted ear wax, and flexible fiberoptic laryngoscopy, or other office procedures deemed necessary by the provider. Some insurance companies bill these procedures under their “surgery” guidelines. You may be responsible for a separate co-pay or deductible for “surgical” procedures after insurance payments and adjustments.

By signing this form I acknowledge that I am requesting evaluation and treatment from ENT Consultants. I understand that I am financially responsible for payment and any residual balance after insurance payments, if applicable. I will also be held responsible for obtaining a referral from my primary care doctor. I understand that during evaluation of my problem, certain common procedures may be required. Different insurance policies may handle the payment of these procedures differently. I have the right to notify the provider prior to a procedure if I choose not to have the procedure: otherwise, my signature on this form represents consent for these commonly done procedures. I will assume liability if a diagnosis is delayed or missed due to my refusal.

This agreement is valid for the duration of your care for any of the providers at Ear Nose & Throat Consultants, Inc. Please feel free to ask questions if you have any concerns regarding this agreement. You are responsible for the timely payment of your account.

Patient / Guardian Signature X_____ _____

Relationship: Self / Guardian / Other_____

Date: _____

A complete description of our financial policies is posted at the check-in desk and is available upon request.