comprehensiveENT
care for all ages

PAYMENT POLICY & AGREEMENT ASSIGNMENT OF INSURANCE BENEFITS

Thank you for choosing Comprehensive ENT for your care. We believe that the patient-physician relationship is based upon mutual trust and understanding, and that it is important for you to have a clear understanding of your rights and responsibilities. We ask that you carefully review the following information, and if you have any questions or concerns, please ask.

DIAGNOSTIC TESTING AND OFFICE PROCEDURES

Comprehensive ENT is an independent medical practice that is not affiliated with any hospital or outpatient ambulatory surgery center. For patient convenience, Comprehensive ENT offers our patients diagnostic testing, which may include the use of scopes. Most insurance companies consider a scope exam to be a surgical procedure, and you may have an additional out-of-pocket expense (deductible, co insurance) in addition to any copayment that your insurance requires. Other procedures that may incur an additional cost to you include ear wax removal, placement of ear tubes and control of nosebleeds.

RELEASE OF PRIVATE MEDICAL INFORMATION

By signing this agreement, you authorize Comprehensive ENT to furnish any insurance carrier(s) or other third-party payers or their agents, attorneys or legal representatives all pertinent medical information that said parties may request concerning your illness or injury, which they deem necessary to determine coverage or which may be required to render payment. You also agree to assign Comprehensive ENT any and all health care benefits to which you are entitled under any policy of insurance and authorize, to the extent permitted by law, payment of those benefits directly to Comprehensive ENT.

By signing this form, I authorize Comprehensive ENT to access data about me, including hospital records or physician's office notes, that may be required for care or billing purposes.

UNPAID BALANCES

Any unpaid balance remaining on your account for more than 60 days after your insurance carrier has paid may be transferred to an outside collection agency for further action.

I understand that should my account have to be referred to a collection agency or attorney, I am responsible for all fees and costs incurred herein, including a collection fee of one-third of the amount referred for collection. I further agree that the city of Richmond, or Chesterfield, Henrico or Hanover counties in Virginia will be appropriate jurisdictions in which to settle any delinquent account.

If your account is transferred to a collection agency, then no further appointments will be made with Comprehensive ENT until the collection balance is paid in full.

FINANCIAL DIFFICULTIES

For patients experiencing financial difficulties, Comprehensive ENT will gladly establish a mutually agreed upon payment plan. If payments are made as agreed, no additional fees or interest will be assessed to the patient's account. If the payment plan goes into a default status, then the remaining balance is expected to be paid in full within thirty (30) days.

RETURNED CHECKS

Comprehensive ENT charges a fee of $25 for any returned check.

CANCELLATIONS AND NO-SHOWS

Due to a large number of last-minute cancellations and appointment no-shows, we have been forced to implement a $30 charge for cancellations with less than 24-hour notice and no-shows. By signing, you indicate that you understand this policy.

PAYMENT POLICIES
By signing this agreement, you agree to pay for the following:

- Any co-payments that are required by your insurance carrier
- Any co-insurance and/or deductibles that are required by your insurance carrier
- Any charges for services that you agree to have performed that are not covered by your insurance plan

INSURANCE CLAIMS
Comprehensive ENT will submit your claim(s) to your insurance carrier(s) for payment. If we do not receive payment from your insurance carrier(s) within sixty (60) days of submitting your claim, we will send you a Balance Due statement. Upon receipt of this statement, we encourage you to contact your insurance carrier if you believe they should pay for the services or call our office to make payment arrangements.

PRIOR AUTHORIZATION AND REFERRALS
If your insurance carrier requires prior approval or a referral to visit a specialist, it is your responsibility to obtain the approval or referral prior to your visit with Comprehensive ENT. If you wish to be seen without a referral or prior approval, you will be required to sign a waiver indicating that you will pay for the visit and any procedures at the time of service. A claim will still be submitted to your insurance carrier, and you will be refunded any money in the event of an insurance payment.

Comprehensive ENT will obtain prior authorization for any surgery or testing that is ordered by our physician.

PRIOR AUTHORIZATION AND REFERRALS
Patients without insurance coverage are expected to bring $200 to their initial visit. If the services total more than $200, payment arrangements for the remaining balance can be set up with our business office.

SELF PAY PATIENTS
Patients without insurance coverage are expected to bring $200 to their initial visit. If the services total is higher than $200 then payment arrangements for the remaining balance can be set up with our business office.

MEDICARE PATIENTS
Comprehensive ENT is a participating provider with Medicare.

Therefore, by signing below, I am requesting that payment of authorized Medicare benefits be made on my behalf to Comprehensive ENT. I authorize any holder of medical information about me to be released to Centers for Medicare & Medicaid Services (CMS) and its agents if required to determine these benefits for related services.

WRITTEN ACKNOWLEDGMENT
Our notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I have declined the opportunity to review or have reviewed a copy of the Comprehensive ENT Notice of Privacy Practices and, if requested, have received a hard copy of the Notice of Privacy Practices.

I understand that I may ask questions of Comprehensive ENT if I do not understand any information on this sheet.

I have read and understand this Agreement. I agree to all the terms of this Agreement. I understand that Comprehensive ENT will provide medical services to me in consideration of and reliance upon this Agreement.

If the patient is a minor, an adult guarantor will be required before Comprehensive ENT provides services.

Patient/Guarantor Name (Printed)

Patient/Guarantor Signature

Date

Minor Patient's Name

Relationship

Witness to Signature

Date