SOUTHWEST EAR, NOSE & THROAT
PATIENT FINANCIAL POLICY

We are committed to building a successful physician-patient relationship with you and your family. Providing a clear understanding of the Patient Financial Policy is important to our professional relationship.

It is the responsibility of the patient to notify our office of any information changes (i.e. address, name, insurance information, etc.).

Co-pays
All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards.

Insurance Claims
Insurance is a contract between you and your insurance company. We will bill your primary insurance company as a courtesy to you. We require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment.

Referral and Pre-authorizations
Certain health insurances, such as HMOs, require referrals and/or pre-authorizations. You are responsible for obtaining any referrals and/or pre-authorizations from your PCP that may be needed by your insurance company. Failure to obtain the referral and/or pre-authorization may result in a claim rejection, making you responsible for payment.

Minors
The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements.

Outstanding Balance Policy
All past due accounts will be sent two statements. If payment is not made, a single phone call will be made to make payment arrangements. If no resolution can be reached, the account will be sent to a collection agency and the patient will be responsible for any collection agency fees.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY.

I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO MY PHYSICIAN AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY NON-COVERED SERVICES.

Date: _____ Patient/parent/guardian: _____