BEACH CITIES ENTS

Adult and Pediatric Ear, Nose, Throat & Sinus

OFFICE FINANCIAL AND PAYMENT POLICY (Updated 07/01/2022)

If you have medical insurance, we will do our best to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our payment policy. You will be asked to update your demographic and insurance information periodically, including providing our office with copies of your insurance card(s). **If you provide us with different insurance from the date of your visit and we are not contracted with your correct updated insurance, the patient is responsible for services rendered.** We are required to obtain your signature for permission to release information to your insurance carrier annually.

NO SHOW POLICY: We ask for a 2-business days notice if you must cancel or reschedule an appointment to allow more availability for patients who desire to be seen. There will be a $50 charge for appointments made which you do not show or do not cancel with 2-business day notice. If you schedule surgery and need to cancel or reschedule, we ask for 2 weeks notice prior to the surgery date in order to allow other patients access to the limited operating room time. If this adequate notice is not given, a $250 deposit will be required to reschedule surgery and will be lost if surgery is cancelled a second time.

Please initial here: _____

As a courtesy, we will gladly submit fees for your covered medical services to your insurance company. However, we expect payment of all services within 60 days. It may become necessary for you to pay your account in full if your insurance company fails to pay for services in an appropriate time period**. It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements**. We will, however, assist you to ensure all plan requirements are met.

Payment for services, including **co-payment, co-insurance and deductible amounts, is due at the time services are rendered. We do not bill secondary insurance for co-pays. We expect copay payments for primary and secondary insurances at the time of visit.** Any non-covered services are your responsibility. Our failure to collect these amounts may be a violation of our contract with your insurance company and may result in civil and criminal penalties and/or expulsion from your insurance plan.

Returned checks, balances older than 60 days and failure to pay account balances as promised will be subject to an external collection service and a **collection fee of $100**. To cover the cost for returned checks, you will be charged an administrative fee of $100 and the cost of certified mailing in addition to the amount of your check. If we receive a bounced check from the bank, we will no longer be able to accept checks from you but will require cash or credit card payment. Also, there is a **$25 charge for any forms** that require completion by our office.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. If there is a dispute with your insurance company, you will receive a letter from our billing service asking for your help by your contacting your insurance company to assist with processing and payment of the services provided to you. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to promptly contact Karmen or Silvia at our billing service, Med Pro Management, Inc. at 818-549-1713 for assistance in the management of your account. Thank you. Your signature below constitutes acknowledgement and acceptance of this policy.

Signature:_____ Date: _____