ALPINE
EAR, NOSE & THROAT, P.L.L.C.

FINANCIAL POLICY

Please take a few minutes to review the following information prior to your appointment. We hope you understand that our financial policies are established to assure the financial resources needed to maintain this medical office for all our patients. We will work with you to ensure that your medical care does not become a financial burden.

● Charges for medical services are due and payable at the time of service. We accept cash, personal checks, and major card credit cards for payment of your account.

● Your insurance policy is an agreement between you and your insurance company. Our relationship is with you, and not with your insurance company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status. We expect any required co-payments, co-insurance, or deductibles due at time of service

IT IS THE PATIENT'S RESPONSIBILITY TO KNOW THEIR BENEFITS. YOUR POLICY MAY APPLY ALLERGY TESTING/INJECTIONS, AUDIO TESTS, CONSULTATIONS, SCOPES (including postoperative scopes) and other office procedures, TO YOUR DEDUCTIBLE; THEREFORE, IF YOU HAVE QUESTIONS REGARDING YOUR BENEFITS, IT IS IN YOUR BEST INTEREST TO CONTACT YOUR CARRIER DIRECTLY.

If you have an appointment with the Audiologist and an ENT or Allergy Provider, your insurance will be billed for each visit.

I authorize Alpine ENT to furnish diagnosis and records of any treatment or examination rendered to me or my child during the period of such care to any or all of the following: Physicians involved in my treatment, Medicare, my insurance carrier(s), or my employer (for work related injuries).

I authorize and request my insurance company to pay directly to the doctor(s) group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

If you do not have insurance, we offer a Self-Pay discount and will require payment at check-in that will be applied toward the charges for that visit. This payment should not be considered payment in full for that visit.

Please sign and date this form. Upon return to the Receptionist, we can provide you with a copy for your records.

I have read and understand the above statement. I understand that accounts 30 days past due are subject to collection proceedings. Should my account become delinquent and turned over to an attorney and/or collection agency, I will be responsible for all costs of collections, legal fees and/or attorney fees.

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Name of Patient (Please Print) Date

_____ _____

Signature of Patient or Representative Relationship of Representative