E.N.T AND FACIAL PLASTIC SURGERY, L.L.C.
DENNIS SURGERY CENTER

Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful.

The purpose of this policy is to let you know what is expected of you in terms of payment for your treatment and the services provided by this office. We respectfully request that you read and sign this agreement prior to treatment at our facility.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN APPROVED BY OUR ACCOUNTS RECEIVABLE COORDINATOR. WE ACCEPT CASH, CHECKS AND MOST CREDIT CARDS._____.
Initial

Regarding Insurance
We participate in a number of PPO and Group Benefit plans and if your insurance is one of those plans we do accept assignment. Any deductibles, co-insurances or co-pays are due at the time of service. We need a copy of your insurance card prior to treatment so that insurance benefits can be verified. If we do not participate with your particular plan, we will be happy to bill your claim for you, but payment for services is due in full at the time of treatment. Your insurance company will in turn reimburse you directly.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, you will be billed for that balance. Any balances over 60 days old will be subject to an interest fee of 1 ½% of the balance due compounded monthly. **You will be responsible for any charge denied by your insurance company deemed not medically necessary and/or not covered. Charges reduced by Usual and Customary Ratings will be evaluated and possibly charged to you as well.**

We do not accept assignment on Medicare patients, but we follow the Medicare Limiting Charge fee schedule, and bill Medicare on your behalf.

You will be responsible for any collection or attorney's fees should your account require collection efforts outside our office.

Any questions you have regarding this agreement should be directed to the Accounts Receivable Coordinator.

Our office MUST be notified 48 hours prior to your scheduled appointment or you will be charged a cancellation fee. A new patient fee will be $250.00 and must be paid BEFORE an additional appointment will be scheduled. A return patient fee will be $100.00. _____.
Initial

Name_____ Date_____