Allergy & ENT Associates of Middle Tennessee, P.C
EST. 1973

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Board Certified, American Board of Otolaryngology
Fellows, American Academy of Otolaryngic Allergy

Adult and Pediatric Diseases of the Ear, Nose, and Throat • Head & Neck Surgery
Allergy Testing and Treatment • Hearing and Balance Disorders

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time.
Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) AND PHOTO ID FOR YOUR FILE.

- **APPOINTMENTS** – 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee of $25 may then be added to your account.
- **INSURANCE** – ALL insurance cards must be presented at the time of your visit. If you do not provide us with accurate insurance information, we cannot file claims in a timely manner and are likely to not get paid by your insurance company. If you have failed to provide us with the necessary information or you provide us with inaccurate information, YOU will be responsible for the unpaid balance on your account. In order to receive maximum benefits from your insurance company, it is highly recommended by our office that you verify that Allergy & ENT Associates and its providers are in-network with your plan or if you are eligible for out-of-network benefits.
- **OUT OF NETWORK BENEFITS** – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. Should you receive payment from your insurance carrier, please forward it to the physician's office.

  Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Allergy & ENT Associates of Middle Tennessee, P.C. for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.
- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER stating that you will be personally responsible for that day's services if your referral is not received.
- **CO-PAYMENTS** – By law, we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. If you are unable to pay your co-payment at the time of service, we will be happy to reschedule your appointment.
- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless financial arrangements have been made prior to your visit.

- **PROCEDURES/TESTING** – Your physician may deem it necessary for you to receive procedures or testing in-office that may fall under "surgery" or other categories by some insurance plans. These may be covered at a different rate than your standard office visit (common use of this may include nasal endoscopy, laryngoscopy, wax removal, allergy and audiology testing). By your signature below, you are acknowledging that you understand this and that you agree to be responsible for the charges deemed payable by your insurance company.
- **"GLOBAL" PERIODS OF COVERAGE** – Surgeries and some procedures may fall under "Global" periods of coverage. These windows of time are designed to allocate time for follow-up care without incurring additional office visit fees. They vary greatly in length of time, as do the accompanied procedures. Please note that the no-fee coverage is ONLY as it relates to the procedure or surgery the patient has had. Should the patient be seen with an additional medical concern, not relating to the global procedure, there may be a co-pay or co-insurance required. Please see your specific health plan for your coverage.
- **NON-MEDICALLY NECESSARY/DELUXE ITEMS –** Most insurance companies do not cover/reimburse the cost of non-medically necessary or "deluxe" items. These items may include, but are not exclusive of, hearing aids, hearing aid accessories, hearing aid batteries, swim earplugs, Otovent kits. Should you wish to purchase items deemed non-medically necessary or non-covered, you will be responsible for the charge.
- **MEDICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

  Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Allergy & ENT Associates of Middle Tennessee, P.C. for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.
- **DIVORCED/SEPARATED/OTHER PARENTS OF MINOR PATIENTS** – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Allergy & ENT Associates of Middle Tennessee, P.C. will not be involved with separation or divorce disputes. Should someone other than the parent have legal guardianship of a patient, it is the responsibility of said guardian to provide legal proof of guardianship to us.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, OR DISCOVER CARD.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.