Mountain Home ENT & Allergy
ADMINISTRATIVE DOCUMENTATION

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.

- **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 $20 may then be added to your account.
- **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, YOUR APPOINTMENT WILL BE RESCHEDULED OR YOU MAY CONTINUE WITH YOUR APPOINTMENT AT YOUR FINANCIAL RESPONSIBILITY FOR THOSE SERVICES.
- **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.
- **OUT OF NETWORK PLANS** – All patients will be responsible for their co-insurance and deductible. If we do not 'participate' with your plan, we will send a courtesy bill to that carrier on your behalf. **Private Insurance Authorization for Assignment of Benefits/Information Release**: I, the undersigned, authorize payment of medical benefits to Mountain Home ENT & Allergy for any services furnished. I understand 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.
- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE** – We will submit claims to Medicare. The patient is responsible for the deductible and 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 Mountain Home ENT & Allergy 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.
- 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. Return check fee is $18.00.
- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Mountain Home ENT & Allergy will not be involved with separation or divorce disputes.

Patient's Signature:_____ Date:_____

Signature of Patient's Representative:_____ Date:_____

Print Name:_____

Relationship to Patient:_____