FINANCIAL AGREEMENT- MELNICK, MOFFITT & MESAROS ENT ASSOCIATES

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) 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 INFORMATION –** Each patient is responsible to provide current, complete and accurate insurance information. Charges for a patient visit for which the patient has provided incomplete, incorrect, out dated or fraudulent insurance information will become the sole responsibility of the patient.

- **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. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day's 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. Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of up to $20 may be added to your account.

- **IN/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. However, should they not pay your claim within 45 days; you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office. In network plan patients will be responsible for any balances due as indicated on their explanation of benefit form.

  Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Melnick, Moffitt & Mesaros ENT Associates 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.

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. In an effort to be fair we offer discounted fees to those who pay in full on the day of their visit

- **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 Melnick, Moffitt & Mesaros ENT Associates 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/SEPERATED PARENTS OF MINOR PATIENTS** – The parent who gave consent for the treatment of a minor child is responsible for payment of services rendered. Melnick, Moffitt & Mesaros ENT Associates will not be involved with separation or divorce disputes.

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

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS OR DISCOVER CARD. WE ALSO MAKE AVAILABLE CARE CREDIT FOR THOSE WHO QUALIFY.

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

By signing off on our Financial Agreement Provision you indicate your understanding and acceptance of the above policies and procedures.