Nancy
Dr. BECKER
EARS, NOSE & THROAT ◦ ALLERGY THERAPY ◦ FACIAL PLASTIC SURGERY

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Medical Release Authorization/Financial Responsibility and Insurance Assignment

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

WE WILL REQUEST A PHOTOCOPY OF YOUR INSURANCE CARD(S) FOR OUR FILES.

- **COPAYMENTS** by law we must collect your carrier designated copy at the time of service. Please be prepared to pay the copay at each visit.
- **NON COPAY PLANS** If your plan does not require a copay and we participate, we will accept the designated fee. You are responsible for any deductible and balance your plan indicates on their explanation 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 a referral, you will be required to sign a financial waiver and pay at the time of service or your appointment may be rescheduled. It is then your responsibility to provide us with the referral as soon as possible.
- **SELF-PAY PAYMENTS** Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE** We will submit to Medicare for the Medicare allowed amount. Then you will be responsible for the deductible and the 20% co-insurance, which can be billed to a supplemental or secondary insurance,
- **MEDICAID** The Medicaid program requires preauthorization for surgery or medical care. Some services that you and the physician deem to be medically necessary or desirable may be considered "non-covered services" by the Medicaid program. If you wish to pursue non-covered services, such as cosmetic surgery, you may request arrangements to be seen as a self-pay patient.

I hereby authorize Dr. Nancy Becker to apply for benefits on my behalf for covered services rendered. If applicable, I request that payment of authorized Medicare and Medigap benefits be paid to Dr. Nancy Becker.

I understand and agree that, regardless of insurance status, I am ultimately responsible for the balance on my account and that my insurance coverage is a contract between myself and the insurance carrier, and not between the insurance carrier and Dr. Nancy Becker, and that I am still fully responsible for all fees. Should timely payment of this account not be made, I authorize Dr. Nancy Becker to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance. Any expenses incurred by such action shall become an additional liability for which I assume responsibility.

AUTHORIZATION: I hereby authorize Dr. Nancy Becker to furnish information to insurance carriers concerning my medical care and I hereby assign to Dr. Nancy Becker all payment for medical services rendered.

Patient Name: _____

Signature of Responsible Party: _____ Date: _____