Financial Policy

Thank you for choosing Comprehensive ENT Center of Texas as your healthcare provider. We are committed to providing you with the best medical care possible. The information which follows explains our financial policy, we ask that you read, sign and return this form to us prior to your treatment.

- All patients are required to provide accurate and complete personal and insurance information prior to being seen be the doctor.

- **ALL** patients are **REQUIRED** to have a credit card on file for all applicable co-pays, co-insurance, deductibles and personal balances (both current and prior), are due at the time of service.

    - Your insurance will be billed as it always has been and you will receive an *Explanation of Benefits* letter that will explain your visit to the office. You will be given a **1 week grace period** to review your *Explanation of Benefits* letter and act on it accordingly.

    - Should you choose not to pay your balance with the credit card on file, kindly contact the office upon receipt of your *Explanation of Benefits* letter and simply inform the office that you wish to use a different form of payment (cash, check, or other credit card).

For your convenience we have answered a variety of frequently asked financial policy questions below. If you need further information about any of these policies, please ask to speak with the Practice Manager.

Forms of Payment accepted	We accept payments if the form of Cash, Check, Care Credit, VISA, MasterCard, and American Express for your convenience.
Co-Payments, Co-Insurance & Deductibles	Payment of the patient's portion (according to your insurance company) is expected at the time of service. If you are unable to make payment on the date of your appointment we can re-schedule your appointment for you.
Returned Checks	For any checks returned to us unpaid by your bank, we will charge a return check fee of $35.00
Past Due Accounts	Any collection or legal fees that we sustain to collect past due balances will be added to your account. These fees are not covered by insurance and will be the patient's responsibility. We will report unpaid balances to all three credit bureaus
Missed Appointments	To avoid holding an appointment time that could have been utilized by another patient it is our policy to charge $150.00 for missed appointments unless canceled at least 24 hours in advance. Our office will attempt to contact you to remind you of your scheduled appointment. Surgical appointments must be cancelled at least One (1) week prior to the surgery date to avoid the penalty fee. This charge is not covered by insurance and will be your personal responsibility.
Fee to have Forms Filled Out	There will be a $20.00 fee to have any special forms filled out by the doctor. For Example FMLA, disability, return to work, and attending physician statement forms
Children's Appointments	A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account, according to our financial policies.
Diagnostic and Lab Testing	Diagnostic testing such as nasal or throat scope, hearing exams and CT scan may be applied to your deductible. If your physician orders pathology or blood work

	while at the Comprehensive ENT Center of Texas the laboratory will bill you directly for their services.
Surgery	For any surgery/procedure you must give a **10 business day** notice if you need to cancel or reschedule. There will be a $500 cancellation fee if not done with in this time frame.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments, co-insurance and deductibles, are my responsibility. You have authorization to charge my credit card for any current or past due personal balance(s) upon receiving my verbal or written permission.

I authorize my insurance benefits to be paid directly to Comprehensive ENT Center of Texas.

I authorize Comprehensive ENT Center of Texas to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Signature of Patient or Legal Guardian: _____

Printed Name: _____ Date: _____