Ear, Nose & Throat
SPECIALISTS OF ILLINOIS

Pediatric
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PRACTICE FINANCIAL POLICY

Thank you for choosing Ear, Nose & Throat Specialist of Illinois as your health care provider. Your understanding of our financial policy and payment for services is an important part of this relationship. If you need further information or assistance about the financial policy, please ask to speak with our Practice Operations Manager.

Insurance is a contract between you and your insurance company. It is the responsibility of the patient/guardian to know and understand the benefits of their particular insurance plan and whether or not their physician is in-network. We will file the claim with your insurance company. We require that you disclose all insurance information, including primary and secondary insurance, as well as any change of insurance information. Not all insurance plans cover all services, and in the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charges.

PAYMENTS:

1. All copayments, deductibles, patient responsibility amounts and past-due balances are required to be collected at the time of service. If our physician is not contracted with your insurance plan, you are required to remit FULL PAYMENT at the TIME OF YOUR VISIT.
2. All HMO insurance REQUIRES A PCP REFERRAL or insurance authorization to see the providers at ENT OF IL. If you fail to present the referral, your appointment will be rescheduled. If you still prefer to be seen, we will collect full payment at the time of your visit.
3. Fees for any procedures, such as nasal endoscopy, ear cleaning, audiological testing, etc., are not included with the office exam and may be applied to your deductible or coinsurance.
4. We have the capability to perform cost of care at the time of service to determine the patient's responsibility based on their insurance plan. Our policy is to collect any deductible, coinsurance and non-covered charges at this time.
5. When you or a family member provide us with a credit card number for surgery, you are giving us permission to use the card to pay the account balance.
6. Each patient will be required to establish financial arrangements for payment of their account.
7. Accounts that have an outstanding balance for over 90 days will be forwarded to an outside collection agency.
8. All of the physicians accept Medicare assignment. Medicare Part B has **a calendar year deductible and a 20% coinsurance.** Secondary insurance may or may not cover your Medicare annual deductible. The patient is responsible for this balance.

CANCELLATION OR MISSED APPOINTMENTS: At least 24 hours' notice is required. If you fail to follow this policy or are a no-show, we will charge you a missed appointment fee.

SELF-PAY: The patient will need to pay a $100 appointment deposit to secure their scheduled appointment. The deposit is a non-refundable amount if you cancel the appointment less than 24 hours before the scheduled appointment time or miss the appointment. A full payment is required at checkout for all services provided on the day of appointment.

I have read, understand and agree to the above Financial Policy. I understand my financial responsibility to make payments for services provided to me and hereby authorize my insurance benefits to be paid directly to the physician's office. I understand that I am responsible for paying for non-covered services. I further authorize the release of pertinent medical information to my insurance carriers.

Patient or Guardian's Signature: _____ Date: _____

A photocopy of this assignment shall be considered as effective and valid as the original.

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