EAR, NOSE, and THROAT
SPECIALISTS of WISCONSIN

FINANCIAL POLICY

Patient Name: _____ **DOB:** _____

Thank you for choosing ENT Specialists of Wisconsin for your medical care! We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship. We do not exclude, deny, or otherwise discriminate against any person on the basis of race, color, national origin, disability, age, or financial status.

We sincerely hope that by sharing our financial expectations we will strengthen the physician-patient relationship and keep the lines of communication open. This financial policy helps us provide quality care to our valued patients. If you have any questions or need clarification of any of the policies below, please feel free to contact our billing department at 920-969-1768. On-line payments can be made at:
https://myhealth.gatewayedi.com/WelcomePatient.aspx?port=573

Payment (Copayment/Outstanding balance) is Due at the Time of Service

- We accept cash, checks, and major credit cards.
- All insurance required co-payments (including Medical Assistance) and fees for non-covered services are due at the time of service. If you arrive without your co-payment, we may ask that you reschedule.

- For patients with out-of-pocket expenses, deductibles, co-insurance, etc. payment will be due in full after insurance has paid. An administrative fee may be incurred if an outstanding balance is not paid in full, and a $35.00 NSF fee will be charged for any returned checks. A $25 processing fee will also be assessed to any outstanding balance(s) that are turned over to our 3rd party collection agency.

- Patient-responsible balances are due when you check in for your appointment.
- In the event you need surgery, we will provide you an estimate of your insurance required deductible and co-insurance amounts, which is due prior to scheduling.
- We request that at least **24 hour** advance notice be given to the office if you will be unable to keep your scheduled appointment. This allows us to release your appointment time to another patient. Patients who repeatedly "no show" for appointments may be discharged from the practice.

Proof of Insurance

- Please bring your insurance card(s) and a valid photo ID with you to each appointment.
- It is your responsibility to notify the Practice of changes in your health insurance.

Self-Pay Accounts

- We designate accounts, **Self-Pay**, under the following circumstances: (1) patient does not have health insurance coverage (2) patient is covered by an insurance plan that our providers do not participate in (3) patient does not have a current, valid insurance card on file (4) patient does not have a valid insurance referral on file or (5) patient declines to provide a social security number for billing purposes.
- Self-Pay patients: please be prepared to pay a minimum of $200.00 on the date of service. There may be additional fees for audiology services, in-office procedures, labs, x-rays, CT, or other supplies/services. A 25% discount is offered at the time of service for payment in full (self-pay only); exclusions may apply (i.e. hearing aids/supplies, etc.).

Referrals

If you have an HMO plan we are contracted with, you are responsible for obtaining the referral authorization from your primary care physician; without an insurance required referral, the insurance company will deny payment for services. As such, you may be asked to *reschedule* if you are unable to obtain the referral.

Our Responsibility to Report Non-Compliance

It is our obligation under many of the insurance contracts to report patients who: repeatedly refuse to pay co-payments/deductibles at time of service, or who repeatedly "no show" for scheduled appointments.

FMLA/Supplemental Income/Disability Insurance Forms: There will be a charge for form completion, which is due at time of drop off or at time of pick up if faxed. Allow 5-7 business days.

Divorce and Child Custody Cases

- In cases of divorce, the individual who receives care is responsible for payment of co-payments, coinsurance, deductibles, and nonparticipating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.
- The parent who brings the child to the office for care is responsible for payment at the time of service no matter if the account is self-pay, participating insurance, or nonparticipating insurance. The Practice does not honor divorce specifics (*e.g., percentage of financial responsibility).*
- If the child has coverage with a participating insurance plan and the proper insurance identification is present at the time of service, the Practice will bill that insurance company. Applicable co-payments, coinsurance and/or deductibles will apply and are due at the time of service.

Billing, Payments and Refunds

- All balances are due in full within 14 days of the statement date.
- If you cannot pay the balance in full within 14 days, please contact our billing department. Outstanding balances are subject to administrative fees.
- It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage. Updating patient information can be done on the patient portal.
- If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same guarantor or financial responsible party.
- We reserve the right to report delinquent accounts to credit bureaus, assess an administrative/collection fee, take other collection action, or terminate you as a patient of this Practice.
- Our Practice treats patients regardless of financial status.

MEDICARE ONLY PATIENTS: We submit and accept assignment on all Medicare claims. As a courtesy, we will file to your secondary insurance. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Ear, Nose & Throat Specialists of WI, SC for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and I authorize release of medical information necessary to pay the claim. This authorization applies to all occasions of service and is in effect until I choose to revoke it.

Signature _____ **Date**_____

- 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 copayments and deductibles, are my responsibility.
- I authorize my insurance benefits be paid directly to *ENT Specialists of Wisconsin, SC*.
- I authorize *ENT Specialists of Wisconsin, SC*, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.
- I authorize *ENT Specialists of Wisconsin, SC* to release to appropriate agencies, any information acquired in the course of my, or the above named patient's, examination and treatment.

Acknowledgement of Notice of Privacy Practices and Financial Policy. I hereby acknowledge that I have reviewed or have been given the opportunity to receive a copy of *ENT Specialists of Wisconsin,* NPP and copy of this Financial Policy for my records.

X Patient/ Guarantor Signature _____ Date: _____

