Pinnacle ENT ASSOCIATES LLC

CHESTER COUNTY OTOLARYNGOLOGY & ALLERGY ASSOCIATES DIVISION

Financial Policy

Dear Patient—

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to contact us at 610-384-8300.

We ask that all patients read and sign our Financial Policy and HIPAA form as well as complete our Patient Information Form and Consent Form prior to having your examination, therapy and/or study. **Medicare patients may be required to sign an Advanced Beneficiary Notice (ABN) should we believe Medicare will not cover your service.**

All insured patients are required to sign the assignment of benefits for payment from the insurance company. We will submit your claim to the insurance company on your behalf, but if the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier. You will be billed for any noncovered services, deductibles, and/or coinsurance. For your convenience, we accept Visa, MasterCard, Discover®, cash and check or money order. There will be a charge of $25 for returned checks.

We require a 24-hour notice when canceling an appointment. You will be charged a fee of $25 for missed appointments or appointments not canceled within the 24-hour period. We require a 48-hour notice when canceling a procedure or special test performed in the office or hospital. You will be charged a fee of $50 for an in-office procedure or special test not canceled 48 hours in advance. We require a 48-hour notice when canceling a procedure performed at an outpatient ambulatory center or hospital. You will be charged a fee of $100 for an outpatient ambulatory center or hospital procedure not canceled 48 hours in advance.

There will be a charge of $12 for form completion. Payment is due on completion.

It is the responsibility of the patient to ensure any referrals, precertification or authorizations have been obtained prior to your appointment. In the event your plan procedures are not followed prior to your appointment, your appointment may be rescheduled.

Delinquent accounts will be turned over to an attorney or collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days. In the event your account is turned over for collection, you will be responsible for all reasonable collection and court costs at the time the account is considered delinquent.

Again, thank you for choosing us as your health care provider. We appreciate the opportunity to serve you.

I accept the Financial Policy, acknowledge that I received the Notice of Privacy Practices for Pinnacle ENT Associates, LLC and have had the opportunity to ask questions.

Patient's Signature _____ Date _____

Assignment of Benefits

I hereby guarantee payment of all charges incurred at the office of Pinnacle ENT Associates, LLC. I hereby assign and direct to pay any and all benefits for medical services under this claim directly to Pinnacle ENT Alliance, LLC. I hereby authorize the release of any medical information requested by the insurance companies.

Patient's Signature _____ Date _____