Pinnacle ENT
ASSOCIATES, LLC
EAR • NOSE • THROAT • ALLERGY • AUDIOLOGY

Patient Financial Policy • Assignment of Benefits • Consent to Treat

Thank you for choosing us as your health care provider. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have questions or concerns about our policies, please ask us during your visit or contact us at (610) 902-6092.

Insurance Information

We participate with most insurance companies. If we do not participate with your insurance company, payment is due in full at the time of service, or we may recommend that you contact your insurance company for a participating provider. All insured patients are required to sign the assignment of benefits for payment from the insurance company. We will submit your claim to participating insurance companies on your behalf. It is the patient's responsibility to notify the organization of any changes in health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.

After your insurance company has settled the claim, you will be billed for any noncovered services, copays, deductibles and/or coinsurance. You will receive a statement for any outstanding balance if you are no longer covered by your insurance plan. Accounts not paid within 90 days will be considered delinquent and will be turned over to a collection agency or attorney. 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.

Some insurance plans require the patient to obtain a referral, precertification or prior authorization for services. Please review your insurance policy to see if any of those are required prior to your visit. If a required referral, precertification or authorization is not on file at the time of the visit, the appointment could be rescheduled, or the patient will be responsible for all charges incurred on this date.

It is your responsibility to understand your individual coverage. If you have questions about what your insurance company or benefit plan will cover, please contact them directly.

Workers' compensation and automobile insurance companies may require additional referrals and/or documentation. We will make a commercially reasonable effort to bill those carriers, but if you do not provide the necessary information, if the benefit is exhausted or in dispute with your workers' compensation or automobile insurance, you will be billed for the services and payment will be due at time of service.

Time of Service Payments

Copays and out-of-pocket charges are due at time of service. For your convenience, we accept most major credit cards, cash and check or money orders. There will be a charge of $25 for returned checks and payment will be required by cash or credit card.

Cancellation and No-Show

We understand that situations arise in which you must cancel your appointment. It is, therefore, requested if you must cancel your appointment, you provide the notice stated in the table below based on the service or procedure. If cancellations are not completed within the requested timeframe, patients will be subject to the fees in the table below. The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. Patients who have missed more than one scheduled appointment without prior notice will be restricted from scheduling future visits unless an exception is granted. Our practice firmly believes that good physician/patient relationships are based upon understanding and good communication.

Service/Procedure	**Required Notice**	**Fee for Lack of Notice**
Office Appointment	48 Hours	$25.00
Procedure or Special Test in Office • Allergy Testing (Prick testing, Intradermal testing) • Speech Therapy Appointments (Fiberoptic endoscopic evaluation of swallowing [FEES], Videostroboscopy) • Audiology appointments (Videonystagmography [VNG], Tinnitus evaluation)	72 Hours	$75.00
Ongoing Tinnitus Appointments	72 Hours	$250.00
Outpatient Ambulatory Center or Hospital	120 Hours (Five Days)	$350.00

Please initial that you have read, understand and agree to this Cancellation and No-Show policy. Patient's Initials: _____

Specialty Services

Our doctors are board-certified in otolaryngology. They specialize in ear, nose and throat issues, and in some cases, sleep medicine, sleep surgery and allergy. As specialists, our doctors offer in-depth testing to better evaluate, diagnose and treat the issues you are experiencing. One or more of the following procedures may be done at your appointment. Insurance companies consider these tests a surgical procedure and, as such, are billed in addition to your office visit. Your insurance may apply additional copay, coinsurance and/or deductible. The below list is not an all-inclusive list, but includes the most common ear, nose and throat office procedures.

- 31231 Diagnostic Nasal Endoscopy*
- 31575 Flexible Laryngoscopy*
- 31237 Nasal Endoscopy Surgical with Debridement (Unilateral or Bilateral)*
- 31238 Nasal Endoscopy with Cautery of Blood Vessels (Unilateral or Bilateral)*
- 69210 or G0268 Removal of Impacted Cerumen (Ear Wax Removal) (Unilateral or Bilateral)
- 31579 Videostroboscopy*

Hearing Tests:

- 92557 Audiogram
- 92550 Tympanometry and Reflex Threshold Measurements
- 92587 Otoacoustic Emissions
- 92567 Tympanogram

Highmark Federal Employee Program charges a $150 copay for the * procedures listed above and potentially others. This copay will be billed to you. You will be responsible for any additional copayment, coinsurance and/or deductible your insurance plan applies to your claim.

Consent to Call, Email & Text

I understand and agree that Pinnacle ENT Associates may contact me using automated calls, emails and/or text messaging. These communications may notify me of appointment reminders, preventative care, test results, treatment recommendations, outstanding balances or any other communications from Pinnacle ENT Associates. I understand that I may opt out of receiving such communications by informing my provider's front desk or scheduling staff.

This consent and authorization will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time. I certify that I have read and understand the above statements.

General Consent to Care

I, the undersigned, for myself, a minor child or another person for whom I have authority to sign, hereby consent to medical treatment, as ordered by a provider, for which such medical treatment is provided through Pinnacle ENT Associates. This consent includes my consent for all medical services rendered under the general or specific instructions of the provider. I agree and acknowledge that Pinnacle ENT Associates is not liable for the actions or omissions of, or the instructions given by, the physicians/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any tests ordered for you. If you have concerns regarding any test or treatment recommended by your provider, we encourage you to ask questions.

Patient Acceptance

I have read and understand the above policies and have had the opportunity to ask questions. This acknowledgment will be in force unless revoked in writing.

Patient's Signature: _____ Date: _____

Assignment of Benefits

I hereby guarantee payment of all charges incurred at the office of Pinnacle ENT Associates. I hereby assign and direct to pay all benefits for medical services under this claim directly to Pinnacle ENT Associates. I hereby authorize the release of any medical information requested by the insurance companies. I give permission to Pinnacle ENT Associates to appeal on my behalf. I also understand and agree this Assignment of Benefits will continue for as long as I am being treated or cared for by the organization and will constitute a continuing authorization, maintained on file, which will authorize and allow for direct payment to the organization of all applicable and eligible coverage benefits for all subsequent and continuing treatment, services, supplies and/or care provided. I also realize that I am responsible for paying any noncovered services, copayments, deductibles or coinsurance amounts due.

Patient Name: _____ Patient DOB: _____

Patient's Signature: _____ Date: _____