



Orlando Ear, Nose & Throat Associates, P.A.

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Ear, Nose & Throat

Head & Neck Surgery, Facial Plastic Surgery, E.N.T. Allergy, Hearing Aids

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Orlando Ear, Nose & Throat Associates, P.A. as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

INSURANCE COVERAGE

- It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is furnished by your insurance carrier.
- We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of your visit, the financial responsibility for payment is yours.

INSURANCE CHANGES

- If you have had any changes in your insurance coverage - even if there is only a small change in the co-payment amount or a change in the expiration date of the policy - you must notify us. Even a small discrepancy on the chain form can lead to a claim denial.

CO-PAYMENTS, CO-INSURANCE AND DEDUCTIONS

- Co-insurance and co-payments are the patient's responsibility. Co-pays are due at the time of visit.
- Deductibles are patient's responsibility. The deductible is determined by the contract you have with your insurance carrier. We do not know how much each person's deductible is and how much has been met at the time of your visit.
- You will be responsible for a \$25.00 service fee if your check is returned for non payment by the bank.

REFERRALS

- It is your responsibility to obtain referrals if required to do so by your plan. We will assist you in obtaining the referral as needed. If your Primary Care physician changes you must notify us immediately and obtain a new referral.

NON-COVERED SERVICE

- All patients are responsible for "non-covered" services if denied by their insurance carrier.

INSURANCE REQUEST

- You are responsible for responding to any request from the insurance company for further information. Not doing so will result in a claim denial and you will be responsible for payment.

INSURANCE PAYMENTS SENT TO YOU

- If insurance payments are sent to you, you are responsible for forwarding them to our office with a copy of the explanation of Benefits (EOB) received.

COLLECTION ACCOUNTS

- In the case your account is forwarded to a collection agency, you are responsible to pay reasonable attorney fees if applicable.

We emphasize that as a medical care provider, our relationship is with you and not with your insurance company. It is your responsibility to know your policy. Again, we thank you for choosing Orlando Ear, Nose & Throat Associates, P.A. as your healthcare provider and are here to help you!

I have read and understand this financial responsibility form.

Patient Name Printed

Date of Birth

Patient Signature

Date

Witness Signature

Date