

NORTH HILLS ENT

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of our bill is part of this treatment and care. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. It is required that our patients read, understand, agree and sign this form prior to treatment.

Financial Responsibility: Payment is required at the time of service. For your convenience, we accept, Visa, MasterCard, Discover, American Express, personal checks, money orders, and cash. We also offer the option of CareCredit, which our business office will be happy to discuss with you. Patients who do not have insurance coverage are required to pay 100% of their charges at the time services are rendered unless a financial arrangement has been approved prior to the visit. Our practice is mandated by law to collect your carrier designated co-pay. All patients with insurance are required by law, to pay co-payments at the time of check-in. If deductibles have not been met, the full amount of the charge is due upon services being rendered.

Returned Checks: There is a \$30.00 charge for all checks returned insufficient.

Insured Patient's: Financial responsibility depends on the type of insurance policy you have with your insurance carrier. It is your responsibility to know the terms of your policy. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. We participate in many insurance plans; therefore, it is your responsibility as the patient to become familiar with your benefits and confirm our participation with your plan. Our benefits coordinator will be happy to assist you if assistance is requested.

In the event your health plan determines a service to be "not covered", you will be responsible for the total charges incurred. Please be aware that when a patient requires a visit to a specialist, there are diagnostic procedures required for appropriate care that cannot be done by a primary care physician. These procedures may be done during the normal course of the exam by the specialist. Although, necessary as a part of a "routine exam", insurance companies often categorize these as procedures. The most common test and procedures performed during your visit may include, but are not limited to:

Tympanometry	Canalith Repositioning	Laryngoscopy
Removal impacted cerumen (wax)	Nasal endoscope	Nasal hemorrhage control
Myringotomy with tube	Audiogram Comprehensive	Nasal endoscopy with debridement
Foreign body removal	Debridement mastoid cavity	

Referral: If your insurance plan requires a referral from your primary care physician, it is your responsibility to obtain the referral prior to your appointment. Please bring the referral with you to your scheduled appointment. If you do not have the required referral your insurance provider will not cover your visit; therefore, you will be responsible for the balance at check-in.

Medical Forms: The fee for preparation of documents or forms is required prior to preparation. In order for our physician to complete each individual request please allow 10 business days for the completion of forms. There is a \$15- \$40 fee for the completion of all medical forms not limited to legal, disability, Insurance, or FMLA (Family Medical Leave Act).

Surgery: Surgical fees are discussed with each patient individually after evaluation. Based upon your insurance benefits if a surgery deposit is required, the deposit is due prior to surgical treatment. The deposit amount is based on the anticipated surgical procedures and is only an estimate. The deposit is due 7 days before the procedure. You may receive an additional bill from North Hills ENT after your claim is processed. Dr. Scott may refer patients to Forest Park Medical Center-Southlake or Texas Pediatric Surgery Center where he holds a financial interest. You always have the option to use an alternative health facility at your discretion.

No Show/Cancellations: In order to avoid additional fees please contact our office if you are unable to keep a scheduled appointment. We ask that you kindly provide us with a 48 hour notice. This courtesy on your part will allow another patient to be seen by our physician in your appointment slot which will allow our office to better serve all our patients. If you do not re-schedule

or cancel your appointment 24 hours in advance, you will be charged a \$35.00 no show/cancellation fee for the missed appointment. The no show fee for a surgery is \$35.00 in addition to a \$100 rescheduling fee. You will also receive an additional invoice from North Hills ENT after your claim is processed which is payable upon receipt.

Minor Patients: A parent or legal guardian must accompany patients who are minors (*17 and under*) on the patient's first visit. The accompanying adult is responsible for payment of the account, according to the policy outlined above.

Collection Agency Services: North Hills ENT, Geoffrey Scott, M.D. P.A. utilizes a collections agency for any unpaid balances. If your account is transferred to collections, any and all fees assessed by the agency will be added to the balance of your account, to include, but not limited to, an additional percentage of your balance and attorney fees. Any patient sent to collections forfeits any future appointments unless the balance is paid in full. North Hills ENT reserves the right to permanently dismiss any such patients at our discretion.

Acknowledgement of Patient Financial Responsibility

I have read, understand and agree to the above financial policy. I understand that charges not covered by my insurance provider, as well as applicable co-payments, deposits and deductions are my responsibility. It is also my responsibility to notify North Hills ENT and/or Geoffrey Scott, M.D. P.A. of any changes in my insurance coverage.

I authorize North Hills ENT and/or Geoffrey Scott, M.D. P.A. to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

I authorize my insurance benefits to be paid directly to North Hills ENT and/or Geoffrey Scott M.D. PA..

Patient's Printed Name

Signature of Responsible Party

Date

Acknowledgement of Fee for Damages

As a practice, we take pride in making our facility comfortable for our patients. There are incidents that may occur when parents or guardians are not supervising their children while in our facility. You are responsible for your child and their actions while they are in our facility. Please do not allow your child to write on, color, or damage any walls, equipment or furniture. A minimum of \$150.00 will be charged to your account with no further services being rendered until the account is current.

**This fee is not covered by your insurance and is your responsibility to pay.*

Signature of Parent/Guardian

Date