



BUCKHEAD ENT

PATIENT INSURANCE FORM

(Please Print)

Current/Valid Insurance Card Required

Buckhead ENT **MUST** have a copy of your current insurance card or you will be expected to **PAY IN FULL** at the time of service. If your insurance changes and you fail to give a current insurance ID card, you will be responsible for service's that were rendered before we receive a current ID card. We will not resubmit your insurance for any dates of service. However, you may file those claims yourself so that you may be reimbursed.

Primary Insurance Information

Insurance Company Name: _____

Phone No.: _____

Insurance ID#: _____ Insurance Group #: _____

Secondary Insurance Information

Insurance Company Name: _____

Phone No.: _____

Insurance ID#: _____ Insurance Group #: _____

Guarantee of Payment for Services & Assignment of Benefits

It is the policy of this office that payment must be received when services are rendered, except in case of surgery. If this applies to you, we will file your claim and you will be expected to pay only the portion that is not covered by your insurance. Please ask about this before leaving the office, if you have any questions.

- In the event that any of the above named companies or individuals fail to make prompt payment, I hereby give my personal guarantee of payment for all charges herein occurred. If this account is placed with attorney or outside collection agency, the undersigned parties agree to pay all reasonable attorney fees and cost of collection. Initial _____

- I hereby authorize insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information in the processing of this claim. Initial _____

- I hereby attest that I have read and understand the statements, guarantee of payment and assignment of benefits outlined above completely. Initial _____

Signature: _____ Name Printed: _____

Relationship: _____ (If not the patient receiving services) Date: _____



BUCKHEAD ENT

OFFICE FINANCIAL POLICY

As part of our commitment to offer excellent medical and professional care to you and your family, we would like to present our financial policy in order to minimize misunderstandings about fees and collection processes. Our fees and collection methods are comparable with those of other ENT specialists in the Atlanta area.

Our financial policies include these requirements:

1. We require complete and honest information on your patient information sheet.
2. We require a copy of your ID card with picture.
3. We require your Social Security Number.
4. We require that co-pays be paid at the time of your visit before seeing the specialist.
5. **We add a finance charge of 21% to any balance that exceeds 60 days.**
6. We expect that past due balances, deductibles and coinsurance balances will be paid before surgery is scheduled.
7. We require that self-pay patients will pay their charges at the time services are rendered, or make arrangements to pay their charges before the visit with our specialists.
8. If your insurance company has a pre-existing clause, coverage for services may be denied. Payment for these services will be your responsibility.
9. We will file to primary and secondary plans only. If you have a third insurance plan, we will be pleased to provide the information so you can file them.
10. If we have to send your account to an outside collection agency, we will add collection and finance fees to the outstanding balance. This is usually 50% of the past due balance added to your account. You may be dismissed as a patient at the discretion of the physician.
11. We accept cash, personal checks, money orders, VISA, MasterCard, Discover card and Care Credit.
12. If your bank returns a personal check, we will add a \$25 fee to your account.
13. If your insurance plan requires a referral for services provided by a specialist, and you fail to obtain one from your PCP listed on your insurance card you will be rescheduled until you obtain a referral.
14. **We charge a \$20 fee for missed appointments. To avoid this charge you must give at least a 24-hour notice of your cancellation.**

This policy is offered by Buckhead ENT in an attempt to develop and sustain a continued professional and pleasant relationship with our patients.

Please read our policy carefully before signing. Please don't hesitate to ask our staff before signing if you have any questions or concerns.

I have read and understand this financial policy.

Patient Signature: _____ Date: _____