

## PATIENT FINANCIAL POLICY

*Thank you for choosing ENT Specialists, Inc. for your ear, nose and throat needs. We appreciate the opportunity to serve you and are committed to providing you with the best possible care. As part of our service to you, we try to contain the ever-rising cost of health care. In an effort to do this, we have implemented the following Financial Policy. Your cooperation with our Financial Policy will allow for a prompt settlement of your charges. As a courtesy to you, we will file all medical claims with the primary and secondary insurance. However, you must provide us with **current** insurance information and notify us immediately when there are changes in this information. Please read and sign.*

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### Norwood

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MA, 02062

P: 781-769-8910

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35 Pearl Street, Suite 200

MA, 02301

P: 508-588-8034

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### Taunton

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P: 508-880-3460

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### Plainville

188 Washington Street

MA, 02762

P: 508-699-1701

F: 508-699-1706

• **Identification:** We require that all patients provide proper identification at the time of the visit. This protects our patients from someone else attempting to use their insurance or identity.

• **Referral:** A referral is a specific authorization from your insurance company for you to see our physician. If your insurance requires a referral we must verify it at the time of your appointment. If we cannot verify the referral, we will offer to reschedule your visit. Many insurance companies will not pay for a visit to a specialist without a referral being in place in advance of the visit. It is the responsibility of the patient/parent/legal guardian to obtain required referrals from the primary care physician and update the referral(s) as needed.

• **Co-payment:** If your insurance requires a co-payment for the visit, it is due at the visit. If you do not have it at the time of your appointment, we will offer to reschedule your visit. Co-insurance and Deductible payments will also be collected at time of service, when known.

• **Method of payment:** We accept cash and most major credit cards. Checks are accepted for co-payments, when the visit is billed to an insurance plan, and for prior balances. There is a **\$25.00** service charge for a returned check.

o You may choose to have ENT Specialists, Inc. retain your credit/debit card information on file with us. With your consent, this information will be securely held to cover future charges and additional fees.

• **Insurance:** It is your responsibility to be aware of your insurance plan coverage, eligibility, deductibles, co-insurance and benefits provisions. Any questions regarding your insurance coverage, eligibility, deductibles, co-insurance and benefits (payment) should be communicated by you directly with your insurance company.

o **You must provide us with accurate and complete insurance information.** Should you fail to provide the information necessary to have your insurance claim properly adjudicated within the filing deadlines of your insurance company, you will be financially responsible for the services rendered by this office.

- o **Medicare Patients:** We submit and accept assignment on all Medicare claims. As a courtesy, we will submit claims to your secondary insurance.
- o **MassHealth Patients:** All Medicaid patients must present a **valid card** prior to being seen. MassHealth patients must have **Referral** from the patient's PCP in order to be seen by our specialists.
- o **Vehicle Accident or Work Related Injury:** If your visit is the result of either circumstance, then we **must** receive your accident insurance claim information as well as your health insurance information, before you can be seen.
  
- **Patients without insurance or not using insurance:** Patients without insurance or not using insurance for the visit are expected to pay their bill in full at time of service.
  
- **Past due accounts:** Accounts must be satisfied within **30 days of receipt of our bill** unless the account is on a scheduled payment plan. If your account is past due, we will need your balance paid in full in order to schedule a future visit.
  - o If your account is unpaid 90 days from the insurance plan adjudication of your insurance claim, and not on a scheduled payment plan, we will take necessary steps to collect this debt including referral to a collection agency and credit reporting bureau.
  
- **Missed appointments:** We understand that occasionally a patient cannot make their scheduled appointment. We ask that you call to cancel your appointment at least **24 hours in advance**, which allows us to schedule another patient. A missed appointment fee may be assessed any patient that does not keep their appointment and that does not call us before the appointment to cancel or reschedule their appointment. Repeated missed appointments may result in our refusal to make any future appointments.
  
- **Completion of forms:** We charge a nominal fee for this service. Completing a form requires time from the physician's schedule to review the chart and complete the forms accurately. The fee must be paid prior to the forms being filled out.
  
- **Minors:** Minors 18 years of age or younger, must be accompanied by a parent or court-appointed legal guardian in order for us to treat them. In divorce situations, the parent who brought the child in is responsible for payment of the bill. We will submit to the necessary insurance carriers. Both parents will be billed for any outstanding balance.
  
- **Hospital surgery, in-office surgery and in-office procedures:**
  - o **Surgery co-payment and deductible:** All, or a portion, of the patient out-of-pocket financial responsibility for surgery will be collected prior to surgery when the patient out-of-pocket financial responsibility can be determined in advance of surgery.
  - o **In-office procedures:** In order for the doctor to evaluate and/or treat your condition, the physician may need to do a procedure or use an instrument that your insurance classifies as a "surgical procedure." What you will pay out of pocket is determined by your insurance plan benefits and varies between insurance plans. High deductible insurance plans are particularly impacted because they reduce monthly premiums by transferring patient expense to

deductibles. Diagnostic procedures that may be classified this way include fiberoptic laryngoscopy and endoscopy. Treatments that may be classified this way include cerumen removal and abscess drainage.

o **Additional testing:** In order for the doctor to evaluate and/or treat your condition, the physician may need to arrange additional testing such as hearing testing, Videostroboscopy, balance testing, etc. Your insurance policy determines what benefit is provided for additional testing.

o **Post-surgery visits:** Office visits after surgery that are related to that surgery and within the “global period” (a number of days determined by your insurance company) are included in the surgery charge with no additional charge or co-payment.

**We appreciate you taking the time to read this information and will be happy to discuss any aspect of our financial policy. Our Billing and Administrative staff may be contacted at 781-769-3222 Ext 1.**

Revised November, 2013

**ENT Specialists, Inc.**  
**Acknowledgment of PATIENT FINANCIAL POLICY**

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Patient Birth Date

*I understand that it is my responsibility to be familiar with my insurance plan and what benefits it provides. This includes what referrals, copayments and deductibles are required.*

*I understand that it is my responsibility to provide ENT Specialists, Inc. with accurate and up to date information about my insurance coverage at the time of my visit.*

*I understand that copayments and deductibles, required by my insurance plan, are my responsibility.*

*I understand that charges not covered by my insurance plan are my responsibility. This includes charges not covered by my insurance plan because I failed to provide the necessary information to ENT Specialists, Inc. at the time of the visit that would allow proper adjudication of the insurance claim within the filing deadlines of the insurance plan.*

*I understand that if I do not call to cancel or reschedule my appointment at least 24 hours in advance, a missed appointment fee may be assessed. I also understand that repeated missed appointments may result in my inability to make future appointments.*

*I authorize my insurance plan to pay benefits directly to ENT Specialists, Inc.  
I authorize ENT Specialists, Inc. to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.*

*I request that payment of authorized Medicare benefits be made on my behalf to ENT Specialists, Inc. for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the Medigap insurer any information needed to determine benefits payable for services from this provider. This authorization applies to all occasions of service and is in effect until I choose to revoke it.*

*I have received, read, understood, and hereby agree to the **Patient Financial Policy**.*

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date