**Financial Policy Page 1**

**Farmington Ear Nose & Throat LLC, Farmington Hearing & Balance LLC, Farmington Sinus Center 501 W. Pine St. Farmington, MO 63640 (573)756-8888**

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment.

All patients must complete our patient information form **before** seeing the physician.

**Regarding Insurance:**

We will file your insurance as a courtesy for you. However, at the time of your visit we do expect you to pay any co-pay, co-insurance and/or deductibles. Pleases remember your insurance policy is a contract between you and your insurance company. We are not a party in that contract unless it is a managed care policy that we have carefully negotiated prior to your visit to this office. In the event that we do not accept assignment of benefits the balance is your responsibility whether insurance pays or not. Please be aware that some, and perhaps all, of the service provided may not be covered service and not considered reasonable and necessary under the Medicare program and/or other medical insurance.

We cannot bill your insurance unless you have provided us with the necessary information. At your initial visit we do require a copy of all your insurance cards.

If Dr. Roberts or one of our providers participates with your insurance, all co-pays and deductibles are to be paid at the time of service. If Dr. Roberts or another provider recommends surgery and you schedule with our office, a surgical deposit is required. This deposit is equal to your remaining deductible and/or co-insurance and is expected five days prior to surgery. After your insurance has been filed and we receive an explanation of benefits, the account balance is the responsibility of the guarantor and payment is expected in full within 45 days. In the event where the deposit was overestimated, we will gladly refund the difference to you.

We gladly accept your personal check. Please be aware that there is a $25.00 fee for any returned checks. You will be responsible for this charge.

In the event you receive state funded benefits, and have a self-pay patient prior to receiving the benefits, no refunds will be given for prior office visits or surgeries.

If Dr. Roberts or another provider is not a participating provider of your insurance, payment is due when services are rendered. We will file your insurance as a courtesy. In the event that your insurance coverages changes to a plan where we are not a participating provider, please refer to the preceding paragraphs.

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**Usual & Customary Rates:**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment of any difference between your insurance company’s arbitrary determination of usual and customary rates and our fees.

**Non-Insured Patients:**

Full payment is due at the time of service, unless prior arrangements have been made with our office manager.

**Minor Patients:**

The adult accompanying a minor are responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, or payment by cash or check at the time of service has been verified.

In accordance with Missouri law, children must be accompanied by a legal guardian before they can be seen by the physician. Otherwise, a written consent has to be obtained for any other person to bring the child to a doctor’s appointment.

**Divorce Decrees:**

Our office is **NOT** a party to your divorce decree. Accompanying adults assume all financial responsibility for the minor.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to Farmington Ear, Nose & Throat LLC, Farmington Hearing & Balance LLC, or Farmington Sinus Center for medical or surgical services or items rendered to me or my dependent by Farmington Ear, Nose & Throat LLC, Farmington Hearing & Balance LLC, or Farmington Sinus Center. Should my insurance carrier deny Farmington Ear, Nose & Throat LLC, Farmington Hearing & Balance LLC, or Farmington Sinus Center payment, I understand that I am financially responsible for the charges. I authorize Farmington Ear, Nose & Throat LLC, Farmington Hearing & Balance LLC, or Farmington Sinus Center to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information.

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Signature of Responsible Party Date**