

**Southeast ENT & Facial Plastic Surgery
Southeast Voice & Swallowing
Financial Policies**

Thank you for choosing Southeast ENT & Southeast Voice & Swallowing. Dr. Johnson and staff strive to deliver the highest quality patient care. In an effort to contain costs, both to patients and insurance carriers, would like to take the time to inform you of our financial and billing policies and procedures.

Insurance:

As a courtesy to our patients Southeast ENT & Facial Plastic Surgery, PC is pleased to assist in the submission of medical insurance claims to insurance companies for payment. Keep in mind that your insurance policy is a contract between you and your insurance company. I understand that it is my responsibility to confirm the provider is a participating provider under my plan. Further, I understand that my insurance company may not cover 100 % of my bill for services provided, and that I will be responsible for payment of any remaining balance. It is becoming common for carriers to consider office procedures, such as sinus scopes as a surgery making them subject to deductible and co-pays.

_____ (patient / guardian initials)

Referrals:

If you have a health insurance that requires a referral, such as an **HMO or POS** plan, we must have referral prior to the patient's visit. Our staff will obtain any necessary Pre-certification or Pre-authorization for surgery or any other procedures, and/or testing that our staff has the authorization to obtain through the managed care plan. Co-payments are required at the time of service.

_____ (patient / guardian initials)

Returned Check Fee:

Any check, for which we receive notification by the bank as having insufficient funds, a fee of **\$35.00** will be charged to the patient.

_____ (patient / guardian initials)

Missed Appointments:

We request that you give us 24 hours' notice when you need to cancel or reschedule an appointment. We have had to establish stringent policies for the benefit of those who need care and at the same time we know that things can change or come up. With that in mind we have developed the following:

- 1) **The first no-show we will call you.**
- 2) **The second no-show there will be a fee of \$25.00.**
- 3) **The third no-show we reserve the right to discharge you from the further care.**

_____ (patient / guardian initials)

Patient Discharge / Collection Fees:

Southeast ENT & Facial Plastic Surgery, PC utilizes an outside Collection Agency to collect on any outstanding balances that do not maintain an active / current payment status with our practice. Additionally, once your account is place with a Collection Agency, you will be responsible for a **35% collection fee** that will be added to the account balance. In the event of failure to pay for medical services, you may be discharged from the services of Southeast ENT & Facial Plastic Surgery, PC until the account is paid.

_____ (patient / guardian initials)

*****I have read and understand the financial policy set forth, and I agree to the terms.*****

Name of Patient (PLEASE PRINT)

Signature of Patient and/or Guardian

Date