SANTA CRUZ
EAR, NOSE & THROAT
MEDICAL GROUP

FINANCIAL POLICY

While we will assist with billing your insurance, you are primarily responsible for:
A . Determining if the medical care you request is covered.
B . Whether or not you need a referral.
C . The full payment of your bill. _________ (Initial)

We do accept assignment with a variety of insurance carriers. You will be financially responsible for any Co-payments, Co-insurance, Deductible or "Non-Covered Services". As a courtesy we will bill our patients' insurance for services rendered. Should payment be denied by the insurance company for any reason, then the full balance shall be your responsibility and due immediately. You will be responsible for informing us of any changes in your insurance coverage, address or phone number. If we are not informed of such changes and this omission results in payment denial, you will be responsible for payment in full. ________ (Initials)

Payment will be due immediately. Co-pays, coinsurance, deductibles and non-covered items will be due upon check out at the time the appointment. ________ (Initials)

We understand your need to see a physician may not have been planned, so your ability to pay immediately may be difficult. To assist you we accept MasterCard, Visa, cash, check, debit cards and money orders. I understand that I will be charged $25.00 for returned checks. _______ (Initials)

Installment plans are available with prior arrangements with a credit card on file. I understand that a 5% convenience charge will be added to my balance and that a $100 minimum per transaction will be charged or the entire remaining balance if less than $100.
Credit cards are kept in a locked safe for security purposes. The credit card on file will be charged any time a patient balance is due and an itemized receipt will be mailed. ________ (Initials)

Families Without Insurance Coverage
Payment for services rendered in our offices are expected at the time of service. Payments at time of service will allow you to receive a 20% discount that will be adjusted off your bill for that date of service. ________ (Initials)

Delinquent Accounts
Our office policy will not permit balances exceeding 90 days. In the event that full payment is not received for our services, we will transfer your account to an outside Collection Agency and a $25.00 fee will be assessed for collection processing. You will then be responsible to make payments directly to that collection agency. If your account is sent to Collection, unfortunately, all of your family members will be dismissed from our practice. ________ (Initials)

Late Cancellation Policy
We require 24 hour notice for rescheduling or canceling your appointment or a missed appointment fee of $50 will be accessed. ________ (Initials)
MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THE BILLING POLICIES OF SANTA CRUZ EAR, NOSE AND THROAT MEDICAL GROUP. I AUTHORIZE SANTA CRUZ EAR, NOSE AND THROAT MEDICAL GROUP TO RELEASE TO MY INSURANCE COMPANY AND AUTHORIZED AGENTS ANY INFORMATION NEEDED TO DETERMINE THE BENEFITS PAYABLE UNDER MY COVERAGE. I FURTHER AUTHORIZE MY INSURANCE COMPANY AND ITS CARRIERS TO DISCLOSE ANY INFORMATION REQUESTED REGARDING CLAIMS FOR MEDICAL BENEFITS TO SANTA CRUZ EAR, NOSE AND THROAT MEDICAL GROUP. A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF AN ORIGINAL.
I REQUEST THAT PAYMENT OF AUTHORIZED MEDICAL BENEFITS BE MADE ON MY BEHALF TO SANTA CRUZ EAR, NOSE AND THROAT MEDICAL GROUP FOR SERVICES GIVEN TO ME BY ITS PHYSICIANS AND STAFF.

____________________________________	____________________________________
Patient's Name (please print)	Name of Parent/Guarantor (please print)
____________________________________	____________________________________
Patient/Parent/Guarantor's Signature	Date