



Northside ENT, Inc. Financial Policy

Thank you for placing your confidence in our physicians. We wish to take this opportunity to review our payment policy for services rendered.

Please contact us with any questions or if you are unable to make a timely payment. We have a direct line to a representative who can help you. (317) 844-6403

ALL CO-PAYS are due *at the time of your visit*. Any co-pays not paid at the time of visit **will have a \$10.00 service charge added** to your account. _____ **Patient Initials**

THERE WILL BE A \$20 FEE for all no shows or appointments not cancelled **within 24 hours of your appointment**.

DEDUCTIBLES may be collected prior to surgery as indicated by your insurance company.

METHOD OF PAYMENT. Cash is best. Checks are accepted, but prepayments for surgeries will delay the surgery until the check clears the bank. Visa and Mastercard are also accepted, as well as access to a line of credit offered by Care Credit.

DO I NEED A REFERRAL? If you are unsure, contact your insurance carrier. If your company requires a referral and we have not received an authorization prior to your arrival at our office, we will make one attempt to call your primary care physician to obtain it. If we are unable to obtain the referral at that time, your appointment will be rescheduled.

HOSPITAL, X-RAY, LAB, PATHOLOGY, AND ANESTHESIA charges are all billed separately by each facility or provider. We are not responsible for knowing rates or procedures for these bills.

ALL SERVICES WILL BE FILED WITH YOUR INSURANCE PLAN, regardless of whether we are a provider on that plan's provider panel. Please be sure we have complete information so as to avoid delays. Balances not paid or adjusted by the insurance plan will be billed to the responsible party/patient for payment.

HEARING AIDS ARE NOT COVERED BY MANY INSURANCE COMPANIES. Special payment plans can be arranged for the purchase of hearing aids.

YOU WILL RECEIVE STATEMENTS A MINIMUM OF TWICE A MONTH when there is an outstanding patient balance. Payment is expected upon receipt or it is considered past due.

IN EVENT OF DEFAULT IN PAYMENT OR IF LEGAL ACTION should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay attorney fees, collection agency fees and other such costs as the court determines proper. _____ **Patient Initials**

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY ABOVE. I AGREE AND UNDERSTAND THAT SUCH TERMS MAY BE AMENDED FROM TIME TO TIME BY THE PRACTICE.

Signature of responsible party

Date

Please print the name of the patient