Alamance Ear Nose & Throat LLP
Financial Policy, Payment Agreement
Refund and Dispute Policy

It is the policy of Alamance Ear Nose & Throat, that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, copay and/or coinsurance payment at each visit. At the conclusion of your visits with us you may be billed for any outstanding balances

If you are covered by health insurance, we will be happy to bill your insurance. Please provide your insurance information to the front office staff and we will verify your coverage as a courtesy. Accepting your insurance does not place financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan. Charges not paid by your insurance company within 90 days will become due and payable by you. If you do not provide current insurance information you will be treated as a self-pay patient.

- Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not guarantee that your insurance will cover our services. **Please remember that you are 100 percent responsible for all charges incurred**. Your physician's referral and our verification of your insurance benefits is not a guarantee of payment.

- If your insurance plan requires a referral or authorization from your primary care physician, we will need to receive the authorization **before** you see our providers. If we do not have the authorization or referral here at the time of your appointment, we will allow you to call your primary care physician or insurance company to get the required authorization. If authorization cannot be obtained, you may sign a medical waiver and pay us as a self-pay patient or reschedule your appointment. **Authorizations and referrals are your responsibility**.

- In the event your insurance company determines a service to be "not covered" you will be responsible for the payment. We try to inform you when services may not be covered; however, it is your responsibility to understand your health insurance limitations.

- We highly recommend you also contact your insurance carrier and check your coverage. Do not assume that you will not owe anything if you have more than one insurance policy.

If you are a self-pay patient, payment is expected in full at the time of service. Any financial arrangements must be made before seeing the physician. We accept the following forms of payment: cash, check, American Express, MasterCard, VISA, and Discover.

Children - Parents, a designated family member or legal guardian are responsible for payment rendered for minor's visit. The responsibility for payments of services rendered to children whose parents are divorced rests with the parent seeking treatment. Any court ordered responsibility judgement must be determined by the individuals involved and cannot be considered by this office. **For patients under 18 years old, a parent or legal guardian must attend the first visit**

Surgical Procedures – may require a deposit, including deductibles, co-payments and coinsurance and must be paid one week prior to surgery.

Medicaid – In order for us to accept and file Medicaid we must have a current Medicaid Card on file for **each visit.** Carolina Access requires a referral from your primary care physician. Without this information, you will be considered self-pay and will pay at the time services are rendered.

Workers' Compensation – We will bill services that have been **pre-authorized** by your employer or Workers' compensation carrier.

No Show Fees - We understand that sometimes appointments must either be cancelled or rescheduled. Because we provide specialized services, we ask that you provide at least a 24 hour prior notice for cancellations or it will result in a no show fee as follows:

1. VNG/ENG, CT or Allergy Testing, New Patient & Consult Appointments - $50.00 no show fee
2. Office visit or PT visit - $25 no show fee

Other fees and charges:

- **$25.00 completion of Family Medical Leave Act (FLMA) forms**
- **$25.00 completion of each Disability Form**
- **$25.00 completion of Return to Work Paperwork**
- **$25.00 returned check fee. When a check is returned we will redeposit it once, if it is returned again we will only accept cash or a credit card for payment and the returned check fee will be added to your account.**
- **$10.00 Prescription refill fee – if during a scheduled appointment you request a refill of a previously prescribed medication and the physician approves the refill there will be no charge, however if you or your pharmacy requests a refill at any other time than a scheduled office visit you will be charged $10 for each prescription refilled.**

Please be aware that any balance on your account over 90 days is subject to intensive collection procedures and may result in denial of future care until overdue balances are paid in full.

If you **dispute** our charges or have questions regarding your bill please call **(336) 395-1340** and one of our Financial Service Representatives will discuss it with you.

Refunds are refunded within 60 days after an overpayment is identified usually after insurance pays. Payments made with credit/debit cards are refunded to the card used to make the payment. Cash and check payments are refunded by check to the address on file.

Hearing Aids returned at the end of your 30 day evaluation period may be refunded less the $100 dispensing fee per hearing aid. If you were fit with behind the ear hearing aids, the cost of the custom ear mold ($50.00 each) is non-refundable.

There will be no refunds for hearing aids kept longer than the evaluation period.

There will be no refunds for lost hearing aids or hearing aids showing obvious signs of abuse.

Payment agreement:

I understand and agree that regardless of my insurance status that I am ultimately responsible for the balance on my account. I accept any and all charges related to diagnosis and treatment, whether or not my insurance covers those services. I agree to pay in full within 30 days of receipt of notice all balances charged against my account.

The undersigned certifies that he/she has read, or has been read and understands the foregoing, has been given a copy thereof, has been given the opportunity to ask any questions regarding the Financial Policy and Payment Agreement. He/she is the patient or duly authorized representative of the patient, having read and understands, accepts this Financial Policy and Payment Agreement.

PATIENT NAME (PLEASE PRINT) DATE PATIENT'S SIGNATURE

RESPONSIBLIE/AUTHORIZED REPRESENTATIVE (GUARANTOR) (PLEASE PRINT) RELATIONSHIP TO PATIENT

GUARANTOR SIGNATURE DATE

Alamance Ear Nose & Throat LLP complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.

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