central oregon
EAR | NOSE | THROAT

Financial Policy

Our Financial Policy is outlined below for your information. Please read it carefully. Our Business Office personnel are available to you; we encourage you to contact us with questions. We will do our best to clarify our policy and avoid misunderstandings.

PAYMENT IS EXPECTED AT TIME OF SERVICE. We accept Cash, Checks, Visa & MasterCard.
CO-PAYS are due and payable prior to service. A $20 charge is assessed for Co-pays unpaid at time of service.
DEPOSITS are due and collected before services on the following:

☐ New Patient: (un-insured)	$250
☐ Insurance Deductibles for HSAs:	$250
☐ Cancellations with less than 24 hours notice: Payable before new appointment is made	$50
☐ No-show: Payable before new appointment is made	$50
☐ Cancelled Surgery: with less than 24 hours notice	$250
☐ Office and Hospital Procedures not Covered by Insurance	$ Cost of Procedure
☐ Third Party Liability (e.g., Auto Accident & Personal Injury)	$250
☐ BALANCES for Office Services are collected at check out	
☐ Surgery (for all non-emergent; non-life threatening cases)	
☐ Insured surgical services	$ Unmet deductible/co-pay
☐ Uninsured surgical services	$ One half estimated charges

Balance due upon receipt of statement. Payment in full prior to services qualifies for TOS discount.
DISCOUNT for PAYMENT IN FULL AT TIME OF SERVICE (TOS) 20%.
This discount is offered to our uninsured patients. To qualify, no subsequent insurance processing will be honored.
Checks returned for any reason from the bank will lose this discount.

PATIENT AND INSURANCE BALANCES are due upon of receipt of statement.

CHILDREN & MINORS: The parent or legal guardian must be present for treatment, following state laws. The presenting parent/guardian is responsible for payment of services. Unaccompanied minors must show ability to pay for services with cash or supply contact with responsible parent/guardian, who must authorize charges and make any payments due at time of service.

INSURANCE

Proof of insurance is required; please bring your insurance information with you each time you visit our office. We participate with many major health plans and will bill your primary insurance as a courtesy. Presentation of proof of insurance does not exclude requirements of our payment policies listed above. Insurance coverage not presented at time of visit may not be honored. Please contact your health plan directly for confirmation of coverage, physician participation and covered benefits. It is your responsibility to obtain any referrals and/or prior authorizations required by your health plan.

Many health plans require us to obtain a waiver or a Medicare Advanced Beneficiary Notice (ABN) before providing you services we expect might be denied for coverage. This waiver or ABN documents that you're aware coverage for services might be denied and you agree to be financially responsible for the charges. In these cases, refusal of signature will result in cancellation of your visit.

RETURNED CHECKS

☐ Checks returned from the bank for any reason	$35
☐ TOS discount will be lost	20%
☐ Co-pay returned are assessed an additional Unpaid Co-pay fee	$20

REBILLING FEE

☐ At time of processing of second and each subsequent billing cycle	$5

COLLECTION ACTION

☐ Accounts placed with a collection agency are assessed an Administrative Fee	Approx $50-$100

PROCESSING FEES

☐ Disability forms. Physicians Statements, FMLA Leave Requests	$25

Financial Agreement

Payment for medical service is due at the time of visit unless prior arrangements have been made.

I authorize Central Oregon ENT, LLC, dba Central Oregon Ear, Nose, & Throat to provide medical treatment for the person named below and agree to pay all fees and charges for such treatment. I authorize the release of information necessary to process the insurance claims and secure payment of benefits.

I understand that as a courtesy my insurance claims will be submitted to my insurance carrier. I agree to pay all charges not covered by insurance or other contract medical programs within ninety days.
I also agree that if it becomes necessary to place any past due amount with a collection agency, I am responsible for any related collection fees.

We participate with many major health plans and will bill your primary insurance as a courtesy. Please contact your health plan directly for confirmation of coverage, physician participation and covered benefits. It is your responsibility to obtain any referrals and/or prior authorizations required by your health plan.

I have read, understand and agree to the Financial Policies of CENTRAL OREGON ENT, LLC.

Patient Name: _____ DOB: _____ Date: _____

Signature: _____ _____

Responsible Party | Print Name if other than Patient