central oregon
EAR | NOSE | THROAT

CONDUCT & FINANCIAL POLICY

Welcome to Central Oregon Ear, Nose and Throat!

We're pleased to have the opportunity to serve you. Your overall health is a partnership between you and your medical provider, and we hope you will interact with us throughout your treatment to ensure you are satisfied with your experience.

Patient Conduct

All Central Oregon ENT staff is expected to treat all patients with respectful and courteous behavior. If you are not treated in this way, please contact Shelly Walden our Practice Manager at 541-312-6798. We also expect patients to treat our staff with the same respect and behave in a polite manner. If this expectation is violated, we have the right to terminate the doctor-patient relationship.

Payment Policy for in-office procedures performed same day as office visit

Be aware that procedures performed in our office will be billed separately and in addition to office visit charges. Some insurance carriers classify these procedures as surgery and apply the charges to a higher deductible amount. The result may be insurance payment for an office visit but not a procedure. In such cases, payment for the procedure will be due from the patient. Be assured that we are following accepted billing and coding guidelines and that all procedures are performed in the best interest of patient care.

Below are some of the common surgical procedures performed in the office:

- Ear Wax Removal
- Ear Injections
- Ear Tube Placement
- Ear Paper Patch
- Ear Debridement
- Flexible Scope
- Audiogram
- Nasal Endoscopy
- Control Nose Bleed
- Microscope Exam
- Nasal Fracture - In Office Care
- Sinus Debridement
- Mouth Biopsy
- Foreign Body Removal Ear
- Foreign Body Removal Nose
- Excisional Biopsy
- Peritonsillar Abscess I&D
- Allergy Injection

CO PAYS: Due and payable prior to service.

PAYMENT METHODS: We accept Cash, Checks, Visa & MasterCard.

DEPOSITS: Due and collected before services on the following:

- ☐ New Patient: **(un-insured)** **$250**
- ☐ Office and Hospital Procedures **not** covered by Insurance **$ Cost of Procedure**
- ☐ Third Party Liability (i.e. Auto Accident & Personal Injury) **$250**
- ☐ Insured surgical services **$ Unmet deductible/co-pay**
- ☐ Uninsured surgical services** **$ One half estimated surgical charges**

**Balance due upon receipt of statement for remaining surgical balance.
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.

RETURNED CHECKS

- ☐ Checks returned from the bank for any reason **$35**

COLLECTION ACTION ....

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

PROCESSING FEES ....

- ☐ Disability forms. Physicians Statements, FMLA Leave Requests........................ **$25**
  Request fees to be paid by patient prior to being filled outby the office.

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.

PLEASE SEE REVERSE SIDE FOR IMPORTANT INFORMATION.

Insurance

________**(Initials)** Proof of insurance is required: **All patients must furnish valid and up-to-date proof of insurance coverage at each visit. Please notify us of any changes in insurance coverage as soon as possible.** 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.

________**(Initials)** 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.

________**(Initials)** 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.

________**(Initials)** 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 **90 days.**

Cancellation of Appointments/No-Show Policy Agreement:

________**(Initials)** If you are unable to keep your scheduled appointment please call our office at least two business days prior to your appointment and reschedule. Late cancellations and missed appointments prevent us from caring for others who could have been seen in the time set aside for you. **If you miss or cancel your appointment with less than a 24hr notice, our office reserves the right to bill you $25.00 for each no-show or late cancellation. The fee will be your responsibility and will not be billed to your insurance.**

Appointment Arrival Times:

________**(Initials)** We ask that our patients check in 15 minutes before the scheduled appointment time. If you arrive late, we'll do our best to maintain the appointment, but we may ask that you reschedule for another time. We appreciate your understanding so that all patients can be seen.

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

I authorize the release of any information my insurance company may need to process my claim, and I authorize my insurance company to issue payment directly to Central Oregon ENT, LLC. In the event that I have a personal balance owing, I will promptly pay balance to bring account current. Failure on my part to pay my personal financial obligations to Central Oregon ENT, LLC could result in my account balances being turned over to collections, I agree to pay any accounting service charges assessed by the billing department on balances over 90 days.

Printed Patient Name: ____ **Date of Birth:** _____________________

Date: _______________________ **Patient Signature:**____

(or Responsible Party for Patient)

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Print Name if other than Patient and please list the relationship of responsible party to the patient.