MONTGOMERY ENT CENTER

Mark E. Grosinger, D.O. Edward C. Tinker, M.D.

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FINANCIAL POLICY

Charges incurred for services rendered in this office are the patientôs responsibility, regardless of insurance coverage. Assignment will be accepted for all insurance with which our practice participates. It is the patientôs responsibility to provide this office with accurate insurance information, and to notify us of any changes in health insurance coverage. If you have questions on network status/participation with your insurance, it is your responsibility to contact the customer service number on your insurance card.

Patient responsibility: If your insurance has an office co-payment, co-insurance, or deductible that has not been satisfied, you must pay this at the time of your appointment.

Authorization: If your insurance company requires authorization to see a specialist, it is your responsibility to contact your primary care physician and request the authorization. Always check with your insurance before your appointment date and make sure the authorization has been approved. If no approved authorization is on file, you are responsible for the entire bill.

Billing: Know your insurance policy. You are responsible for any rejected claims, non-covered expenses, deductibles, co-insurance/co-payments. Statements are sent monthly. Cash, check, money order, Visa and Mastercard are acceptable means in which to pay the balance. When no payment activity or contact from the patient in regards to an unpaid balance and all means have been tried and met with no response, the account could be turned over to a collection agency or pursued legally. All outstanding balances must be paid in full prior to any elective surgery. There is a $35.00 fee for checks that are returned for insufficient funds.

Dr. Grosinger and Dr. Tinker feel that a patient presenting to our office with sinus, allergy, throat or voice complaints require a thorough examination of that specific area. In some cases, that can only be accomplished through the use of an endoscope (our providers use two different types of scopes.) This examination is essentially painless, and in many cases, can be accomplished quickly. A procedural fee will be submitted to your insurance carrier for this procedure. In most cases, we will accept your insurance companyôs allowance for this procedure. You will be obligated to pay only the deductible and or co-payments that are applied to this claim. Please note: some insurance companies may list this diagnostic procedure as ñsurgeryò on the insurance remittance advice you receive.

If you require a procedure, the practice will contact your insurance company to confirm eligibility and an estimate of your covered benefits. Prior to the procedure, you are required to pay in full for your estimated out-of-pocket expense related to the procedure. Any remaining balance is due within thirty (30) days of our receipt of payment from your insurance company. Any credit balance will be refunded to the responsible party within (30) days of our receipt of payment from your insurance company. Credit balances under $25.00 will not be returned without a written request after 3 years.

Missed Appointment Policy: If you fail to contact our office to cancel or reschedule your appointment within 24 hours prior to your appointment time or do not appear for your scheduled appointment time, we will charge a fee of $75.00 for new patient visits and $50.00 for an established patient visit. Missing appointments or cancelling without sufficient notice could also result in termination from the practice.

Informing our patients about our financial policy assists us in providing the best service to our patients. Thank you for taking the time to read this policy statement. Should you have further questions or comments, please kindly contact our Office Manager. I hereby understand the financial policy of this office. I guarantee payment of all charges incurred for the account of the below patient. I further agree to pay any attorneyôs fees, court costs, and related collection fees incurred. I also agree that my employer may be contacted to verify employment status.

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Patient Name Date

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Guarantor Signature