EAR·NOSE·THROAT SPECIALISTS
of Northern Virginia, P.C.

PROFESSIONAL HEARING SERVICES
The Dizziness and Balance Center
The Hearing Aid Center

FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. We believe that advising you in advance of our office policies allows for good flow of communication.

Financial Responsibility Consent & Assignment Of Benefits - I hereby accept that I am financially responsible for all services rendered on my behalf by Ear, Nose & Throat Specialists of Northern Virginia, p.c./also d.b.a Professional Hearing Services. For those insurances from which the practice accepts assignment, I accept personal responsibility for all co-payments, deductibles, and non-covered services, as indicated by my insurance coverage. I certify that the information I have reported with regard to my insurance coverage is correct. I authorize payment directly to the practice for services for which the Practice accepts assignment.

Medical Records - I consent to the use and disclosure of my protected health information (PHI) for treatment, payment and operations and such other purposes that is permitted under the federal Health Insurance Portability and Accountability Act (HIPAA) without written consent.

Insurance Coverage - I accept that it is my responsibility to understand my insurance benefit plan. It is my responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to undergoing a procedure, and what services are covered. I accept that I am responsible to provide this office with all required information regarding my health insurance coverage. If the insurance company you designate is incorrect, you will be responsible for all unpaid balances. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visits. In addition it is your responsibility to determine from your insurance carrier what co-payments and deductibles are due. I accept that co-payments are due at the time of service.

Uninsured Patients - I accept that if I do not have current health insurance coverage, the entire payment for any services performed shall be paid at the time of service, payable by cash, credit card, or check. Dishonored or returned checks will incur a $35.00 service fee.

Collection Of Outstanding Balances - All outstanding balances shall be due within 30 days. Unless we have agreed to other payment arrangements in writing, it is important that you pay all past due balances, in their entirety, prior to or at the time of your visit. Balances that remain outstanding for a period of 90 days or more may be referred to a collection agency or attorneys' office. If your account is referred to a collection agency, you will be responsible for paying a collection charge equal to 30% of your outstanding balance, which is in addition to your outstanding balance and any applicable interest. If your account is referred to an outside attorney, you will responsible for paying all reasonable attorneys' fees and court costs, which are in addition to your outstanding balance and any applicable interest.

Missed Appointments - We understand that there are times when you must miss a scheduled appointment or surgery date due to emergencies or other obligations for work or family. Please be advised that there is a fee if you miss any of these appointments or do not call to cancel your appointments with proper notice. You will be charged a $50 fee for all no-shows and appointments not cancelled with 24 hrs.notice; a $100 fee for special testing not made with 48 hrs.notice and a $200 fee for surgical procedures not cancelled at least 10 days in advance. These fees are non refundable and they are not covered by your insurance company. Additionally, if you have had 2 concurrent, late cancellations/no shows, you may be subject to dismissal from the practice.

Endoscopy Or Laryngoscopy Procedures -During your evaluation with us your provider may recommend a study such as endoscopy or laryngoscopy. Please be advised that some insurance companies require us to code these procedures under surgical codes. This could result in separate fees that are charged as surgical procedures and may have a different deductible under your coverage.

Release Of Medical Records - Medical records created by our office shall only be released pursuant to your express written authorization in accordance with HIPAA or other controlling laws (or under other circumstances as required by law). As a courtesy the first copy will be free of charge. In accordance with Virginia law, for all additional copies, we charge a $10.00 research fee, postage and a photocopying fee of 0.50 cents per page up to 50 pages and then 0.25 cents for each additional page thereafter.

By signing below, patient or responsible party acknowledges that he or she has read and understood the foregoing Financial Policy and agrees to be bound by the terms and conditions set forth therein. Refusal to sign this form may result in our practice not being able to provide services to you, and could result in cancellation of your appointment. If you have any concerns about signing this form, please request to speak directly with our office manager.

Thank you for choosing our practice.

_____ _____

Signature of Patient or Responsible Party **Date**

_____ _____

Print Relationship of Responsible Party **Print Name of Patient or Responsible Party**