Villa Rica Ear, Nose and Throat LLC Financial Agreement

Chattahoochee Healthcare DBA Villa Rica Ear, Nose and Throat

FEE INFORMATION

Our office policy is that payment is required at the time services are rendered. The standard charges for the office are:

Initial Office Visits:	*$95.00-$234.00*
Steroid Shots:	*$18.00-$33.00*
Antibiotic Shots:	*$50.00-$132.00*
X-Rays:	*$87.00-$136.00*
Hearing Tests:	*$73.00-$190.00*

Please indicate below how you will be paying for today's copay/coinsurance or charges:

CASH　　　　CHECK　　　　CREDIT CARD

INSURANCE

If you have coverage through an insurance plan that we have an agreement with, we will file your insurance. However, if your insurance does not pay your bill or as much of it as you think they should, you, the patient, is ultimately responsible for the bill. It is our policy to collect your copay/percentage at the time of your visit.

If you have coverage through an insurance plan that we DO NOT have an agreement with, you will be expected to pay the charges in full at the time of service. We will be happy to provide you with the necessary insurance forms for you to file for reimbursement. Please note that it is your responsibility to make sure we participate in your insurance.

SURGERY

If it is determined that surgery is required for the patient, we will take care of contacting your insurance for prior approvals and benefits. Once your percentage is determined, you will be notified and your percentage will be due prior to the surgery date.

RETURNED CHECKS

If for any reason a check is returned to our office, there will be a $35.00 returned check fee. You will be expected to pick up the check and pay by cash or credit card with all future payments paid in this manner as well.

NO SHOW POLICY

Due to an increasing number of no shows, we reserve the right to treat you as a walk in patient (with no guarantee of being seen) if you have two or more consecutive no show appointments or a cumulative total of three. When you fail to keep an appointment, you deny that time period to another patient who could have been seen.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

X ______________________________　　　　X ____________________

Signature of patient or responsible party　　　　Date