

Patient Name: _____ **Date:** _____

Primary Insurance Carrier Name: _____

Policy Holder Name: _____ Relationship: _____

Date of Birth of Insured: _____ Social Security # of Insured: _____

Policy ID#: _____ Group # _____

Secondary Insurance Carrier Name: _____

Policy Holder Name: _____ Relationship: _____

Secondary Insurance Policy #: _____ Group #: _____

If Patient is a Child Responsible Person/Guardian Information:

Name: _____ Relationship: _____ Phone: _____

Address: _____

Social Security # _____ Date of Birth: _____

Insurance Policies and Payment Procedures

In an Era of Managed Care we cannot possibly know the terms of your individual policy. Please review your plan booklet or check with your insurance representative if you are unsure whether services at Florida Gulf Coast Ear, Nose and Throat are covered under your policy. It is your responsibility to know if the services you are having needs to be pre-authorized or not.

Most insurance plans have a specialty office visit co-pay; this co-pay applies to the doctor visit portion of your bill only. If the doctor provides a service at the same visit, such as using the microscope to look in the ear or uses an endoscope to look in the nose; a scope to look into the throat; order hearing tests, allergy tests and allergy injections, this is considered an ancillary charge with your insurance company and most likely you have a deductible to be met and then a percentage of out of pocket amount which is usually 20%. This is in addition to the co-pay assigned to specialists.

If we order hearing tests or allergy testing we recommend that you call your insurance carrier and ask them how these services are paid in a doctor's office.

You will be expected to pay your deductible and co-payment amounts at the time services are rendered. If you are unable to do so, we ask that you contact the office manager to see if other payment options can be made.

Signed: _____ Date: _____

PAYMENT POLICY:

We accept Medicare assignment and bill secondary insurance only if you have a Medigap plan (one where Medicare automatically crosses over). Your co-payment and deductible are due at the time of service; we accept payment in the form of cash, checks or credit cards. Non-Medicare patients are expected to pay at the time of service unless we have an established relationship with your insurance carrier.

In order to establish optimal relations with our patients and to avoid misunderstanding and confusion regarding payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered. We accept payment in the form of CASH, CHECKS, and CREDIT CARDS (Visa and MasterCard Only). When you provide a check as payment you authorize us to either use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic funds transfer, funds may be withdrawn from your account as soon as the same day you make your payment. A returned check fee of \$25.00, or maximum allowable by law, will be electronically debited from your account in the event your electronic transfer is returned from your financial institution.

Note a \$40.00 fee will be charged to all patients who fail to cancel their scheduled appointments within 24 hours of the appointment. A fee of \$20.00 will be charged to patients whose prescriptions need to be refilled while up north. We try our best to make sure that patients have enough refills on their prescriptions before they leave for the north, and feel the time and cost of calling or faxing prescriptions long distance has to be the responsibility of the patient.

MEDICAL/PAYMENT AUTHORIZATION:

I hereby authorize my Health Insurance plan to make direct payment to Florida Gulf Coast Ear, Nose and Throat, LLC, Dr. Samuel L Hill III, Dr. Patrick M. Reidy for all services provided to me, unless I have paid in advance for said services.

I hereby authorize Florida Gulf Coast Ear, Nose and Throat, LLC to release any information acquired in the course of my treatment to my Health Insurance carrier, if needed for payment of my claim.

I hereby authorize photocopies of this form to be as valid as the original, and authorize the above Medical/Payment Authorization for as long as Florida Gulf Coast Ear, Nose and Throat, LLC remains my physician.

I understand I am responsible to pay for services provided to me, and any account balance that has not been paid within 90 days is subject to be sent to collection, and I am responsible for the 40% collection fee, charged by the Collection Agency.

SIGNATURE OF THE PATIENT OR LEGAL GUARDIAN AGREEING TO THE ABOVE MEDICAL/PAYMENT AUTHORIZATION:

SIGNED: _____ **DATE:** _____