

PLEASE INITIAL ALL 6 STATEMENTS AND SIGN BELOW
2010

Dr. Kirkner and Dr. Greenberg are here to provide you with the most appropriate medical care. Certain tests or procedures may have to be performed, either here in our office or at an outside facility. Any procedures that we do in our office may be subject to patient's surgical deductible and, therefore, the fees for these procedures may become the responsibility of the patient. Any tests that are performed, requiring a specimen to be evaluated at an outside facility, are going to be sent to **Allegiance Health**. Please note: **Allegiance Health routinely sends specimens to outside facilities.** If you know your insurance carrier will **not** pay for the results to be examined at **Allegiance Health**, please let the receptionist/nurse know right away.

_____ **Initial**

I understand that all **co-pays** and **deductibles** are **due at the time of service, before seeing the doctor. I understand that my insurance carrier has required ENT Associates of Jackson PC to collect my copay/deductible at the time of service. If I fail to pay my required co-pay at the 'date' of service I understand there is an additional \$10 billing fee, (not billable to any insurance carrier).**

_____ **Initial**

I understand that once I receive a statement from ENT I am required to make a payment in **30 days** or **contact** the billing department. If no resolution or payment is received I understand I am **required to pay a \$10 re-billing fee every month a payment/resolution is not made, (not billable to any insurance carrier).** I understand I will be **responsible for any rebilling, collection, court and attorney fees incurred if my account goes to collections.**

_____ **Initial**

I understand if I have **an insurance company requiring a referral to be seen** at ENT Associates of Jackson PC by my primary care physician, **I will make sure it is here for my appointment.** If the referral is **not** here at my appointment time, I understand that **my appointment may be delayed or rescheduled. (ex: HPM, Aetna, BCN, Tricare)**

_____ **Initial**

I understand that if I fail to call **24 hours** in advance to cancel or reschedule my appointment I have scheduled, **I will be required to pay a \$30 fee, (not billable to any insurance carrier) before another appointment can be made.**

_____ **Initial**

I authorize the release of information to all my insurance companies. I authorize payment directly to ENT Associates of Jackson PC. **I authorize the use of this statement on all my insurance submissions.** I assume responsibility for any charges not totally paid by my insurance company. I understand that ENT Associates of Jackson PC is not responsible for any balance that my insurance company will not cover.

_____ **Initial**

I have read the above information and I know I am **required** as a health plan participant, cash patient and/or an ENT Associates of Jackson PC patient to follow the above statements and am acknowledging so by signing the line below.

PATIENTS NAME _____

SIGNATURE _____

DATE _____ **2010**

(employee)WITNESS _____ **2010**

revised 1-19-09/jb