SOUTHERN UTAH EAR NOSE THROAT ALLERGY AUDIOLOGY AND FACIAL PLASTICS

617 E RIVERSIDE DR SUITE 201 ST GEORGE UTAH 84790 P-435-628-3334 (all information is kept private)

Please print legibly

Patient Name:

Last: First: Middle:

Mailing Address: City: State: Zip:

Physical Address**:** _____

Birthdate: Cell/Preferred Phone#: Do you prefer Text or Voice (please circle one)

Gender: Marital Status: Age: Social Security#:

Race: Ethnicity: Email:

Responsible Party: Responsible party address:

Responsible Party Birthdate: Is Responsible Party Also Insurance Subscriber? Y or N

If not: Insurance Subscriber: _____ Insurance Subscriber Birthdate: _____

Emergency Contact: Relation: Phone#

Primary Care Provider: Last seen: Referred By:

Insurance: _____

Notice of Privacy Policy and Authorization to release information (HIPAA): I understand that Southern Utah Ear Nose and Throat Offices cannot release any of my medical records or information. I hereby authorize this person (s) to have access to my medical records:

_____ (spouse or family)

_____ (physician/medical facility)

This will stay in effect until I send a letter in writing to Southern Utah Ear Nose and Throat stating to terminate this agreement. I automatically authorize my Insurance Company and referring doctor/provider to receive any and all of my medical records.

SELF PAY PATIENTS: I understand there are extra charges/fees for scopes, debridement's, audiology testing and/or any other service provided besides the consultation. These charges may be billed to you after the date of service. We can provide you an estimate of fees upon request.

Financial Agreement and policy: I understand it is my responsibility to know my insurance benefits, rules, coverage and eligibility. Consultations, scopes, sinus debridement's, audiology testing, CT scans, allergy testing and any other service performed may require an additional co pay or may be applied to my deductible/co insurance by my insurance company.

PLEASE TURN THIS FORM OVER FOR DETAILED FINANCIAL POLICY AND SIGNATURE

Thank you for choosing our office as your ENT providers. We are committed to providing you with quality health care. Please read our financial policy in detail, feel free to ask any questions you may have, please sign in the space provided. A copy will be provided to you upon request.

1. **Insurance:** We participate with most insurance plans in Utah, including Medicare and most Utah Medicaid's. We do not participate in 'health share' plans. If you are on a high deductible insurance plan (deductible over $2,000 dollars) **our office will collect a deposit upfront**, before your visit. Most high deductible insurance plans process the whole visit/claim to your deductible. Due to this we collect $100 to $400 before your visit depending on what you are being seen for. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. For insurance patients, I hereby assign and authorize payment of my insurance benefits directly to Southern Utah Ear Nose and Throat. I guarantee payment of all charges incurred on my behalf and understand I am responsible for any remaining amount after insurance payments and adjustments. A denial from my insurance company does not release me from my financial obligations. I will assist with any appeals or help to get my insurance company the needed information to process and pay my claims. I understand that Southern Utah Ear Nose and Throat bills insurance companies as a courtesy and that I am responsible for providing payment of my claims if the insurance Company does not pay my claims. If an account is sent to collections the terms are 30 days from the date of service of invoice. If you live outside of Utah, your insurance may not pay for some/or all of your services. We will bill Nevada, Arizona and California insurances as a courtesy but if they do not pay for some/or all of your services, you may owe for the office visit/procedure/testing or surgery in full if insurance does not provide payment.

2. **Co-payments and deductibles:** All co-payments and deductibles must be paid at the time of service, before the visit or procedure. After the claim processes, some deductible amounts will be billed to you. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered breaking the rules of our contract with the insurance. Please help us uphold our provider contracts by paying your co-payment and/or deductible at each visit or upon the claim processing.

3. **Non-covered services:** Please be aware that some of the services you receive from our office, may be not covered or are considered investigational by your insurance company. Examples may be hearing instruments, scopes, CT scans, Audiology services, Latera implants, Clarifix, etc. We will always check with your insurance first to go over your benefits or see if they need authorization but you may have to pay for these services in full if insurance does not pay the claim or pay after we appeal. Please ask questions before you receive any of these services.

4. **Proof of insurance:** All patients must complete our patient information form before seeing the provider. We must obtain a copy of current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of your claim in full.

5. **Claims submission:** We will submit your claims to your insurance company after your visit, procedure or surgery as a courtesy. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract. Not providing them with this information may subject you to pay the bill or claim in full.

6. **Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, we will appeal or supply your insurance company with the requested information. If they do not pay, the balance will automatically be billed to you.

7. **Nonpayment:** If your account is over 90 days past due, you will receive a statement stating that you have a certain number of days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. Should collection become necessary by legal suit or other means, the patient or responsible party agrees to pay all costs of collection, including agency fee, 35% of the balance assigned with or without suit. By signing, you acknowledge that Southern Utah Ear Nose and Throat, including its attorneys and assignees, may have legitimate business purposes in calling you to discuss this account and we will bear the cost of any charges associated with such calls. Once an account is turned over to collection agencies, you must contact them to resolve the balance.

8. **Missed/No show appointments.** Southern Utah Ear Nose and Throat has a no show and cancellation policy of $50 dollars if you no show your appointment or cancel under 24 hours of the appointment date. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointments.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for a specialist office. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.
By signing, you have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party Date