PATIENT FINANCIAL POLICY

STRICKLAND EAR CLINIC aims to provide the very highest quality of care in a patient centered environment. Compliance with this financial policy will help us reach this goal. Please take time to read this document and contact us with any questions.

INSURANCE

1. It is important to realize that your insurance plan is a ***contract between you and your insurance company not the clinician.***
2. You are responsible for understanding your insurance plan benefits and services.
3. You are responsible for all of your charges regardless of the type of insurance you have.
4. You are responsible for informing our office of any pre-authorization required for specific procedures or specialty referral. Failure to notify us could result in non-payment by your insurance company.
5. You are financially responsible for all fees that are excluded/non-covered by your insurance plan, or amounts over and above your insurance limitations. ***Again, it is your responsibility to know your insurance policy coverage and benefits.***

We will submit a claim to your insurance company for your initial/annual evaluation. Your co-pay is due at the time of service. We will supply any paperwork necessary for you to submit to your insurance company for any other services and/or devices. You are responsible for any amount due on your account.

PAYMENT ACCEPTED

For your convenience we accept cash, Mastercard, VISA, AMEX, Discover Card as well as personal checks. We also offer financing through several credit companies for those patients who qualify.

COLLECTION PROCEDURES

Once an account is placed in collection status all future services must be paid in full at time of service. Any balance assigned by a collection agency will be assessed a 30% fee to offset the recovery expense. If an account is placed in collection it can negatively affect your credit.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly by presentation thereof, unless credit arrangements are agreed upon in advance, charges shown by statements are agreed to be correct and reasonable unless protested within 30 days of billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services and/or durable medical equipment rendered to me or my family, I/we agree to pay reasonable attorney fees or such costs as the court determines proper. It is agreed that payments will not be delayed or withheld because of insurance coverage or the pendency of claims thereon, all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original).

DEVICE RESTOCKING FEE

A 15% restocking fee per device purchased will be assessed on any refunds.

NOTICE: Do not sign this agreement before you read and agree to the conditions set. You are entitled to a copy of this agreement at the time you sign if you wish.

SIGNATURE:_____ DATE:_____

PRINT NAME: _____