



Starfish Pediatric ENT — OF CHARLESTON —

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day’s services.
- **CO-PAYMENTS** – By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.
- **OUT OF NETWORK PLANS** – You will be responsible for any balance your plan indicates as patient responsibility on their explanation of benefits form. When the provider you are scheduled to see does not participate with your insurance, your plan may not cover out-of-network services, leaving you to pay the full cost. If your plan does cover out-of-network services, you may be assessed a higher co-pay, deductible and co-insurance for out-of-network care. You will be responsible to pay these higher amounts plus any difference between the allowed amount and the amount the out-of-network provider charges for the service. Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Starfish Pediatric ENT for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.
- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Starfish Pediatric ENT for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

- **DIVORCED/SEPERATED PARENTS OF MINOR PATIENTS** – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Starfish Pediatric ENT, LLC will not be involved with separation or divorce disputes.
- **ALLERGY SHOT PATIENTS** - If you are an allergy patient who is consenting to receive allergy shots as part of your treatment plan, it is important that you understand your benefits and responsibilities related to the cost of this type of therapy. Once you consent to receive allergy shots, your doctor will write a prescription for allergy serums specifically for you based on your particular allergies. Our central mixing lab will verify insurance coverage and will notify you if there are any large out-of-pocket expenses before preparing the serums and submitting a bill to your insurance company. If there is a large out-of-pocket amount due on your part, we can discuss a payment plan, or you may decide to decline to receive allergy shots. Alternatively, if only a copayment is due, then the lab will prepare your serums and submit a charge for the vials to your insurance company (CPT 95165). This office will notify you when the vials are ready so you may schedule an allergy shot visit. At each of these visits, you will be billed for the administration of the injection (CPT 95117). A copayment will generally also be due at each of these shot visits.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, OR DISCOVER CARD.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

I hereby agree that you may contact me for whatever reason concerning my account on any and all of the phone numbers I have provided to you, including but not limited to home phone, work phone, cell phone or any other phone number.

Patient’s Name: _____ DOB: _____

Responsible Party Signature: _____ Date: _____

Print Name: _____ Relationship: _____