FINANCIAL POLICY-MEDICAL CONSENT

Please check one of the following:

_____ I **<u>Do</u>** have medical insurance coverage

_____ I **Do <u>Not</u>** have medical insurance coverage

1. **Payment of Services** -Payment in full for deductibles, co-payments, supplies, equipment and all non-covered services determined by your insurance are due when services are rendered.

2. **Filing of Insurance Claims**- As a courtesy to our patients, this office will file all insurance claims we participate with for services rendered. However, we do not file auto accident claims.

3. **Returned Checks**- A $35 return check fee will be charged for all dishonored checks returned by a financial institution.

4. **Self Pay**- Our Policy is for total charges to be paid in full when services are rendered.

MEDICARE PATIENTS ONLY
20% OF THE ALLOWABLE BILLED CHARGES IS EXPECTED AT THE TIME OF SERVICE

I hereby authorize and consent ENT of GA to provide medical care for the patient named below. I also consent to release any medical information necessary to process insurance claims on my behalf. I hereby authorize and assign all payments made by my insurance directly to ENT of Ga for claims submitted on my behalf. I have read and understood the above financial policy.

Date ______________________

Print Patient Name ______________________________

Patient Signature (Guardian if patient is minor) __________________________