Financial Policy

Patient Name: _____ Date of Birth: _____

As a patient of **The Grand Island Ear, Nose and Throat Clinic**, you are required to sign a financial responsibility and authorization for treatment form that will be a permanent part of your file.

Insurance: Our office accepts most insurance and we will submit a claim to your insurance company on your behalf. Some services may not be covered, and you will be responsible for 100% of those charges. If you decide to see one of our physicians that does not participate in your insurance plan, you will be responsible for all fees and charges.
***We are Out-of-Network with some insurance plans, including but not limited to:** Ambetter, Medica Elevate & Inspire, BCBS Premier Select Blue Choice & Preferred Care Blue, UHC Exchange Benefit Plan & Optimum Choice, and Aetna plans.
ULTIMATELY, it is the patient's responsibility to verify if our physicians are in network with their insurance company.

Referrals: If your insurance company requires a referral from your primary care physician, it is your responsibility to obtain the referral prior to your appointment and have those papers with you at the time of your appointment.

Workers Compensation: Please have injury/accident information available at your appointment, such as date of Injury, claim number, insurance company address, phone number and contact person. Patients will be financially responsible for services related to accidents/workers comp if proper documentation is not received and/or the claim is denied.

Copayments: Your insurance REQUIRES that we collect your designated co-pay **at the time of service.** Please be prepared to pay the co-pay at the time of each visit.

Cancellations: To ensure efficient scheduling and respect for all patients, we ask that you call to cancel or reschedule your appointment if you are unable to attend. Failure to provide notice will result in the following fees:
***First occurrence- $30.00 charge *Second occurrence- $50 charge *A third occurrence may result in termination of care at our clinic.** (If you believe you have an emergency or extenuating circumstance, please contact us to discuss)

Estimated Surgical Expenses: Should you require surgery, you are responsible for all fees incurred. These fees can include co-insurance, deductibles and any out-of-pocket expenses for our surgeon's fee, for which your insurance company makes you responsible. Prior to your surgery, you may be required to make a deposit, and your previous account balance must be in good standing.
Surgery cancellations or rescheduling requests made with less than 48 hours' notice will incur a $150 fee.

Outstanding Balances: After claims have processed with the insurance company, any remaining balance due is the responsibility of the patient. If you are unable to pay your balance in full, please contact our office (308-384-5700 opt 3) to arrange a payment plan. Our office does not apply interest or late fees to outstanding balances. However, we do ask that all accounts be paid in full within two years of our acceptance of insurance payment or claim processing.

Suggested payment schedule:	$0.00-500.00	Paid within 6 months
	$500.00-1500	Paid within 12 months
	$1500-2500	Paid within 18 months
	$2500 & above	Paid within 24 months

Forms of Payment: We accept cash, checks, Visa, MasterCard, American Express, and Discover. A fee of $35.00 per check returned from your bank for non-payment or insufficient funds will be assessed to the patient's account.
WE DO NOT PARTICIPATE WITH CARE CREDIT.

Patient/Responsible Party Signature: _____ Date: _____

☐ **Self Printed Name: _____ Relationship to patient**: _____