The ENT Center of Central Georgia

Central Georgia Head & Neck Surgery Center

The Allergy Center Georgia Hearing Institute

540 Hemlock Street
Macon, GA 31201
478-743-8953

6084 Lakeview Road
Building B Suite 100
Warner Robins, GA 31088
478-333-2235

222 Perry Highway
Professional Building B
Hawkinsville, GA 31036
478-892-8359

FINANCIAL POLICY **Patient Name** _____

Thank you for choosing The ENT Center of Central Georgia (ENT) and/or Georgia Hearing Institute (GHI) as your health care provider. The following is a statement of our financial policy, which we require you to read and sign prior to treatment. We do require payment at the time of service. We accept CASH, CREDIT CARDS AND CHECKS and if needed, offer an extended payment plan which is available with PRIOR CREDIT APPROVAL.

Co-Payments and Deductibles

Office visits typically require a co-payment from your insurance company. Exceptions may include post operative visits for a determined period of time for some surgical procedures (office visit portion only). A deductible is a portion of the bill that is the responsibility of the patient to pay before an insurance company will cover the service. An office visit with our physicians will include a face to face encounter and evaluation. Generally, a copayment is required for the visit. In addition, some services and ALL procedures performed in the office require the patient to meet their deductible before insurance pays benefits. If you have not met your deductible, you will be responsible for full or partial payment, depending on your insurance contract. Procedures performed in the office are considered the same as surgery to the insurance company, and are billed as surgery.

Diagnostic Procedures

Your office visit today may include a scope being placed in your nose or throat. This is considered a diagnostic procedure, which will be coded to your insurance company as an invasive or surgical procedure. Depending on the specifics of your policy, your insurance carrier will pay all, part, or none of the cost of this procedure. **It is the responsibility of you, the insured, to be aware of the limits of your policy prior to this procedure**. Any charges not covered by the insurance carrier will be the responsibility of the patient. YOU HAVE THE RIGHT TO REFUSE THE DIAGNOSTIC PROCEDURE.

Guarantee of Payment and Insurance Coverage

It is the policy of the office that you must pay for services when rendered except in the case of surgery and hospitalization. If this applies to you, we will estimate your responsibility of the charges and collect those (when possible) prior to surgery. We will then file your claim and you will be expected to pay any additional portions not covered by your insurance. If you have any questions, please ask about this before you leave the office.

In the event that my insurance company(ies) or other individuals fail to make prompt payment or deny services due to non-eligibility, I hereby give my personal guarantee of payment for all charges herein incurred. This includes all charges related to office visits, procedures performed, diagnostic testing, co-payments and deductibles. If this account is placed in collections, the undersigned agrees to pay the balance plus costs incurred to collect the debt.

I hereby authorize insurance benefits to be paid directly to the physician, and I am financially responsible for any non-covered services. I also authorize the physician to release my medical information in the processing of this claim.

If my insurance requires a referral or authorization for my visit, I am responsible for making sure the referral is obtained from my primary care physician or insurance carrier. I also understand that if the referral/authorization is not received prior to my appointment, I agree to pay for all services rendered on the day of the visit.

I have read the Financial Policy. I understand and agree to this Financial Policy.

_____

PLEASE INITIAL *(full signature/date below)*

PRIVACY POLICY ACKNOWLEDGEMENT STATEMENT

I hereby acknowledge that I have been made aware that The ENT Center of Central Georgia and Georgia Hearing Institute have a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a patient, I understand and acknowledge the following:

1. ENT and GHI have a privacy policy in effect in their office.
2. ENT and GHI have made this policy available to me for review by placing a complete version in the waiting room.
3. ENT and GHI have made me aware, that as a patient, I can request a copy of this policy for my personal file.

Upon review of the above statements, please sign below acknowledging that you have been advised of the privacy policy implemented by The ENT Center of Central Georgia and Georgia Hearing Institute and have read and understood the acknowledgement form. If you desire a copy of the Privacy Policy, please request one at this time.

Check One: ____ No, I do not want a copy, but acknowledge the Privacy Policy exists. ____ Yes, I do want a copy of the Privacy Policy.

SIGN HERE

_____ _____ _____

Patient Signature (Guardian or Rep. if patient is a minor) | Relationship to patient if minor | Date