

# Sierra Nevada Ear, Nose and Throat Associates

## **FINANCIAL POLICY**

Our practice accepts most insurance and bills your insurance as a courtesy. All deductibles, co-pays and percentages of the bill that are the responsibility of the patient are expected to be paid at the time of service. Extenuating financial circumstances will be handled in a confidential manner between the patient, the physician, and the patient service representative.

If your insurance is an HMO (Health Maintenance Organization) or EPO (Exclusive Provider Organization), it is your responsibility to first obtain the required authorization from your Primary Care Provider (PCP) prior to the appointment, and present the authorization at the reception desk before being seen by the doctor.

We reserve the right to charge the following fees:

- \$35 for cancelled appointments, or missed appointments without 24 hour advance notice
- \$75 for cancelled VNG's without 48 hours advance notice
- \$75 for cancelled allergy testing without 48 hours advance notice
- \$250 for cancelled surgeries without a 7 day advance notice
- \$10 for secondary paperwork including but not limited to disability and FMLA paperwork

I have read this Financial Policy and consent to being responsible for any unpaid medical bills for services received.

\_\_\_\_\_  
Patient / Parent / Legal Guardian (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (if patient is a minor)

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## **HIPAA Exceptions**

Is it OK to leave message with your spouse? YES / NO

Is it OK to have message left on my answering machine with personal information? YES / NO

If you would like us to discuss your care with a friend or family member please list their name below:

\_\_\_\_\_  
\_\_\_\_\_

## **RECEIPT OF PRIVACY NOTICE**

I have received or been offered a copy of the Notice of Privacy Practices from Sierra Nevada Ear Nose and Throat Associates concerning the use and disclosure of how Protected Health Information is handled by the practice.

\_\_\_\_\_  
Patient / Parent / Legal Guardian (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (if patient is a minor)