



ENT MEDICAL SERVICES, PC  
2615 Northgate Drive  
Iowa City, IA 52245-9565

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## FINANCIAL POLICY

This agreement is between ENT Medical Services, PC as **creditor** and the **patient/guarantor** named on this form. By executing this agreement, you are agreeing to pay for all services that are received.

It is your responsibility to know the requirements of your insurance company. This includes participation, referral requirements, second opinion, prior approval, pre-certification and out-patient and /or in-patient status. You are also responsible for all co-payments, co-insurance and insurance deductible as required by your insurance plan. You must be aware of any pre-existing wait period, a ridered condition or waiting periods outlined by your insurance carrier.

### MONTHLY STATEMENTS

If you have a balance on your account, we will send you a monthly statement. It will show current balance, insurance adjustments/payments, and *monthly interest on balances over 60 days*. Unless ENT Medical Services, PC approves other arrangements in writing, **the balance in full on your account is due and payable within 60 days from the date of service.**

### INSURANCE

Insurance is a contract between you and your insurance company. We are not a party to this contract in most cases. We gladly submit your claims and will assist you in receiving the maximum benefit from your plan. All plans, however, have limitations and some may not cover 100% of the fees for our services. If your insurance company requires a referral and/or preauthorization, **you** are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in lower or *no payment* from the insurance company. Please remember, that although we will assist you with your claim, you must assume full responsibility for payment.

### DIVORCE

In the case of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for the subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

### UNINSURED PAYMENT OPTIONS

Payment is required in FULL from the date of service, unless other arrangements have been made, in writing, with ENT Medical Services, PC. A 15% discount is given if your balance is paid in full on the date of service.

### EXTENSIVE TREATMENT and/or LARGE BALANCES:

We understand that medical bills can add up quickly and sometimes patients aren't able to pay the balance in full within the 60 days. We would suggest securing a bank loan for balances over \$1000.00 as we are unable to extend credit for long periods. Other options include an ACH (debit bank accounts) without interest, monthly payments with check, credit card, or money order with interest of *1.5% monthly or 18% annually*.

### WORKERS COMPENSATION

We require written approval or authorization by your employer and/or worker's compensation carrier PRIOR to your initial visit. If your claim is denied, you are responsible for payment in full.

## PAST DUE ACCOUNTS

If your account becomes past due, we will take necessary steps to collect this debt, which could result in turning your account over to a collection agency or an attorney.

## SUGGESTED MONTHLY PAYMENT

\$0 - \$50	Payment in FULL
\$50 - \$150	2 monthly payments
\$150 - \$300	3 monthly payments
\$300 - \$500	4 monthly payments
\$500 - \$2000	6 monthly payments
\$2000 - \$3000	12 monthly payments
\$3000 - \$5000	18 monthly payments
\$5000 - Above	24 monthly payments

## PAYMENT OPTIONS

\_\_\_\_ CASH

\_\_\_\_ CHECK

\_\_\_\_ CREDIT/DEBIT CARD

\_\_\_\_ MONEY ORDER

\_\_\_\_ CareCredit®

\_\_\_\_ ACH monthly debit from your checking or savings account for balances over \$300.00

- A monthly finance charge of *1.5% or 18 % annually* is added to unpaid balances over 60 days.
- **Required Payments:** ALL co-payments must be paid at time of service.
- **Failing to pay co-pays and deductibles could result in loss of your insurance coverage.**

We understand there will be some exceptions to these policies and are willing to work with you whenever possible.

## EFFECTIVE DATES

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Responsible party, if not the patient Date: \_\_\_\_\_

\_\_\_\_\_  
Signature Date: \_\_\_\_\_