Financial Policy Statement and Agreement

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICE IS RENDERED, unless our staff has approved payment arrangements in advance. We accept cash, checks, Visa or MasterCard.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier.
3. Not all services are covered benefits in all contracts. Some insurance companies select certain services they will not cover.
4. Medicare patients please be aware that we are "participating providers." This means that we have signed a contract to accept their fee schedule for reimbursement for services delivered to Medicare patients. Although we are allowed to and do bill Medicare our usual fee schedule, your responsibility for payments to us of "co-payments and deductibles" are limited to the amounts based the "par amount" or the fee schedule dictated by Medicare which is the "Allowed amount for participating physicians."

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims for certain services is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered (unless specifically excluded by a particular managed care contract). We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account since all accounts over 90 days are turned over to our collection service for payment. In the event that your account is turned over for collection, you will be responsible for all collection service fees, interest and all legal fees associated with collecting the account, including but not limited to attorney's fees of 33 1/3 % and all court costs. **I further understand that I may be billed for appointments not cancelled 48 hours before my scheduled appointment time**.

In addition to the above I understand that I may be charged a reasonable fee for the copying of my medical record for any purpose. I understand that I may also be responsible for the cost of postage if necessary. Alexiou Hearing & Sinus Center/Valley ENT will also retain my medical record for a period of six years from the date of my last visit after which Alexiou Hearing & Sinus Center/Valley ENT may destroy my record according to VA laws and regulations.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance on my account for any professional services rendered.

I authorize the release of any medical or other information necessary to process my claim. I also authorize payments under my insurance programs to be made directly to Alexiou Hearing & Sinus Center/Valley ENT for any services furnished to me.

This authorization also permits the release of information by HCFA (its intermediaries or carriers) on any UNASSIGNED Medicare claims to the above.

I further permit copies of the authorization to be used in place of the original.

Patient Signature (or responsible party)

Patient Name (or responsible party) (please print)

Date (01/08)