

**EAR, NOSE, AND THROAT CONSULTANTS  
OF EAST TENNESSEE, P.C.**

**Financial Policy &  
Acknowledgement of Receipt of Privacy Notice**

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**Proof of Insurance**

Please bring your insurance card(s) with you to every appointment. It is your responsibility to inform the front desk of any changes in insurance coverage or when the claim should be billed to a Medpay (auto insurance), liability insurance company or worker's compensation company rather than your regular primary insurance due to cause for treatment. We will file your insurance claims for you, unless you instruct us otherwise.

**Payment is Due at the Time of Service**

All copayments, deductibles, coinsurance, and payment for services not covered by patient's insurance policies are expected at the time of service. We accept cash, personal checks, MasterCard and Visa for your convenience. If you have Medicare and you are to receive a service that Medicare may deem as "medically unnecessary" according to HCFA payment guidelines, you will be required to sign a waiver (advanced beneficiary notice) prior to treatment and will be responsible for payment at the time of service. For most services, Medicare patients will be required to pay the 20% copay, based upon the current Medicare Fee Schedule, at the check-out counter unless proof of a secondary policy is evident. If your copay is based on a percent (for example, 20% is patient responsibility) and you do not have a secondary policy, please be prepared to pay a minimum of \$10.00 on the date of service.

**ENTCET's Responsibility to Report Non-Compliance**

We are obligated under many of the managed care contracts to report patients who repeatedly refuse to pay copays and deductibles at the time of service or who repeatedly "no show" for appointments. Please know that if you are reported, you could possibly lose your health care benefits. You may contact your employer's human resources department for further clarification of your benefits and obligations.

**Billing, Payments and Overpayments**

If you make an overpayment on your account for a particular service, a refund will only be issued if there are no other outstanding debts on your account or on any other account containing the same guarantor or financially responsible party. Patient balances unforeseen at the time of service will be billed to the address you have provided for billing purposes. It is your responsibility to inform us of any change in address, phone or employment. All balances are due in full within 14 days of the billing date. If you cannot pay the balance in full within 14 days, please contact our office to see if you qualify for any special payment arrangement options. Once an account has been turned to a collection agency, we are not at liberty to arrange a payment plan with you.

**Past Due and Delinquent Accounts**

Failure to meet your financial obligations may result in reporting you to the credit bureau, filing for a judgment in small claims court or other collection action against you. You may also be terminated as a patient of ENTCET. All attorney fees, court costs and other expenses related to collecting your account will be added to your outstanding balance. A \$25.00 service charge may be added for each returned check.

**ONE TIME AUTHORIZATION**

I have read, understand and will comply with ENTCET's Financial Policy above.

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

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**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

I acknowledge receiving today a copy of ENTCET's Notice of Privacy Practices.

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_