FINANCIAL POLICY

Central Florida ENT Associates, P.A.
515 East Garden Street
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This is an agreement between Central Florida ENT Associates, P.A., a Florida Professional Corporation, as creditor, and the patient/debtor named on this form. In this agreement the words, "you", "your", and "yours" mean the patient/debtor. The word "account" means the account has been established in your name to which charges are made and payments credited. The words "we", "us", and “our" refer to Central Florida ENT Associates, P.A., Ratnamani Lingamallu, M.D, Vicki Cornish, ARNP and Marcy O’Brien, Au.D..

Monthly Statement:
You will receive a monthly (30 day) statement. It will include all pending services and charges on your account. It will also show any insurance/patient payments, contract adjustments, and any insurance/patient balances. All patient balances are due upon receipt of your statement.

Payment options if you have no insurance:

- You may choose to pay by cash, check, or credit card on the day that treatment is rendered. We accept Visa, MasterCard, and Discover. We expect payment in full unless prior arrangements have been made.
- On extensive treatment and/or follow up care, you may prefer to secure a bank, cred it union, or other third party financing for the entire amount and make payments to the lending institution.
- We offer special financing through Care Credit. You may see one of our staff for an application.

Payment options if you have insurance:
All deductibles, coinsurances, and/or copayments must be paid by you prior to services being rendered. You may choose to pay by cash, check, or credit card. We accept American Express, Visa, MasterCard, and Discover. If you cannot pay deductibles, coinsurances, and/or copayments prior to treatment, we will require that you reschedule your appointment.

Payments:
Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within 30 days.

Charges to Account:
We have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid prior to services being rendered.

Insurance:
Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. If we are participating with your insurance company, we will bill your primary insurance as required. Although we will estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by your insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization will result in one of the following: rescheduling of your appointment, a lower payment, or no payment from your insurance company.

If your insurance carrier is requesting information from you, your account balance will be made your responsibility and payment will be expected from you until such information is returned to your insurance company.

It is your responsibility to see that your carrier pays timely and correctly. Any services found to be not covered by your insurance company will be your responsibility and must be paid prior to services performed.

Credit History:
You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Required Payments:
Any copayments, deductibles and/or coinsurance as stated by your insurance policy must be paid prior to services being rendered.

Returned Checks:
There is a fee for any checks returned to us by your bank. This will be the maximum fee allowed by law.

Missed Appointment Fee:
Patients who do not cancel their appointment 24 hours prior to the time of the appointment will be charged a "no show" fee. We make every effort to confirm your appointment the day before. It is your responsibility to keep your file updated with your current address and telephone numbers.

Past Due Accounts:
If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all collection costs incurred. If we have to refer collection of your account balance to an attorney, you agree to pay all attorney's fees which are incurred, plus all court costs. In case of suit, you agree the venue shall be in Lakeland, Florida or Bartow, Florida, County of Polk.

Waiver or Confidentiality:
You understand is this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, that fact that you received treatment in our office may become a matter of public record.

Divorce:
In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those 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 form the other parent. The parent bringing the child in for treatment will be responsible at the time of service for any applicable copayments, coinsurance, or deductibles.

Transfer of Records:
You will need to request in writing if you want to have copies of your records released to another doctor or organization. You authorize us to include all relevant information, including your payment history. We may charge a fee for this service. We require one week for review and to prepare your records.

Worker's Compensation:
We require written approval/authorization by your employer and/or your worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury:
If you are being treated as part of a personal injury lawsuit or claim, we require verification form your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of health insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case. We have the right to agree to accept your case and if we do, we must have a "letter of protection" from your attorney to protect all financial interests.

Bankruptcy:
If you file for bankruptcy, we will require a proof of claim immediately. After the date the discharge of debt is ordered, all services will be on a cash only basis. This will include all charges incurred 90 days prior to the filing of your claim, with the court's permission. If your request is dismissed in court, payment is due in full immediately.

Co-signature:
If this or another financial policy is signed by another person, that co-signature remains in effect until cancelled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date:
Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in force and effective for as long as you are a patient.

By executing this agreement, you are agreeing to pay for all services rendered.

Patient's Name: _____ Responsible Party: _____
(If not the Patient)

Signature of Patient or Responsible party: _____ Date: _____

Co-signature: _____