NEVADA ENT & HEARING ASSOCIATES

Financial Office Agreement

Patients Name:_____ **Date of birth:**_____

The doctors of Nevada ENT & Hearing Associates participate in many insurance plans, but not all of them. It is your responsibility to know whether the doctor you are seeing is a participant on your plan. Charges for services rendered by Nevada ENT will be will be submitted directly to your insurance company for payment, as a courtesy to you. You will be responsible for any amount not paid by your insurance. Should you not have insurance coverage, you will be responsible for payment at the time of your visit.

All copays are due at the time of service.

*** Patients should note that not all medical and surgical services are covered by insurance. Patients are directly responsible for such fees. You will be informed and billed accordingly at the time of your visit.

*** Please be aware that you may be subject to an additional **co pay** by your **Insurance Company** if you are seen by the **Doctor and the Audiologist** on the same day. you are responsible for any balance due after your insurance has processed and paid your claim

*** It is your responsibility to notify this office of you preferred hospital, lab and radiological facilities, and if prior authorization is required.

*** it is your responsibility to make sure your insurance processes and pays your claims in a timely manner.

Authorization

I authorize Dr Joshua Meier, Dr David Mathis, Dr Anthony Zamboni, Dr Jenny Van Duyne, Dr Thomas Killeen, Dr Richard Johnson, and/or Dr Richard Panelli to release any information acquired during my examination and treatment for the purpose of claim payment. I further authorize payment directly to the physicians for benefits due me for this service. I recognize and accept personal responsibility for any balance remaining after payment of such benefits.

Signature: _____ Date: _____

Signature of Guardian:_____ Date:_____