Policy for Contracted Insurance Companies

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask to speak to any member of our billing team.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO SCAN YOUR INSURANCE CARD(S) AND A PHOTO ID FOR YOUR FILE.

1. CURRENT INSURANCE CARD : patients cannot be seen if they present an expired insurance card. They will have the opportunity to pay for the visit or reschedule when a current card can be provided
2. We will review your insurance card(s) at every visit. All insurance changes must be given to us at the time of service. If your insurance changes and we are not notified, you will be responsible for all charges. We will not bill your insurance for any charges before the change notification.
3. We will gladly file your insurance claims. Copays, deductibles, and co-insurance amounts are collected at the time of service. Any durable medical supplies like hearing aids are not included in our contract and will be an out of pocket expense. As a courtesy to you, insurance forms for services rendered will be completed by our office with your primary insurance carrier. We will file secondary insurance if we are given appropriate insurance information. There are some things for which we cannot accept responsibility.
4. We **DO NOT** file Medicaid as a secondary insurance unless Medicare is primary.
5. Co insurance and Deductibles: You are responsible for the payment of any amount that your insurance carrier deems to be co-insurance or deductible. Due to our contractual obligations with your insurance company, we are not able to write off co-insurance or deductibles.
6. Co-payments: By law we MUST collect your insurance carrier designated co-pay. This payment is expected at the time of service
7. For those patients who are members of an HMO or POS insurance plan etc, it is the patient's responsibility to get a current authorization from their primary care physician. Please verify with the receptionist before your visit that you have a current authorization. If you do not have authorization, you will be responsible for visit charges at the time of service or will have to reschedule your visit until an authorization can be obtained.
8. Self pay patients: Payment is expected at the time of service in full unless financial arrangements have been made prior to your visit.
9. Divorced/separated parents of minor patients. The responsibility of payment for services rendered to any dependent children whose parents are legally separated or divorced rests with the parent who brings the minor to the visit. Any court ordered responsibility judgments must be determined between the individuals involved without the inclusion of our office. RCENT will not be involved with separation or divorce disputes.

10. Supplies: any supplies that you receive from our office must be paid in full at the time of service. Insurance companies do not cover miscellaneous supplies or administrative work. Disability forms,CMLA forms, leave of absence forms, letters regarding airline tickets or travel and/or any requested correspondence that is not associated with reimbursement of a claim will be charged to the patient prior to completion of the form and will be based on time and volume.
11. Missed or late cancellation of appointment. There will be a $50.00 charge incurred for a no show appointment, and a $200.00 fee for no show or cancellation of surgery and office procedures without a 48 hour notice.
12. Statement procedure: We will mail a statement to the address you have provided once we receive payment from your insurance carrier. In the event that payment is not received from you within 30 days, a second past due statement will be mailed. If we still do not have payment within 30 more days, we will make every effort to notify you that the account is being turned to Equifax and will impact your credit rating.
13. Financial/insurance responsibilities: I authorize the release of any medical information necessary to process the insurance claim form for services rendered by Raleigh Capitol Ear Nose and Throat. Ialso authorize payment of benefits to Raleigh Capitol Ear Nose and Throat.
14. Medicare Assignment: (if applicable) I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of the authorization to be used in place of the original request payment for medical insurance benefits to the party who may be responsible for paying for treatment. Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding information. Regulations pertaining to medicare assignment of benefits also apply.

- I have read and understand the financial policy for Capitol Ear, Nose and Throat.
- Patient Name: _____
- Date of Birth: _____
- Signature: _____
- Date: _____

Instructions:
Print this form, then fax or bring to the office.
Fax (919) 571-8135