RALEIGH CAPITOL
EAR, NOSE & THROAT

CONSENT FOR TREATMENT & FINANCIAL POLICIES

TEL: 919.787.1374
FAX: 919.571.8135
RaleighCapitolENT.com

CONSENT FOR TREATMENT

By signing this form, I am giving my permission for the physicians and staff of Raleigh Capitol Ear, Nose & Throat (RCENT) to treat me, including the performance of testing and/or procedures, as deemed necessary in the exercise of their professional judgment. This consent is given for both in-person visits and telehealth visits.

PAYMENT FOR SERVICE

I understand I am responsible for paying the full amount for all services on the day of service unless RCENT has an agreement with my insurance carrier. If I am insured, I authorize RCENT to release all information necessary to secure payment. I further understand my share of the cost of the services, e.g., co-payments, co-insurance, and deductibles, will be collected at time of service.

INSURANCE CLAIMS

As a courtesy to you, RCENT will file claims for payment with your insurance carrier. Your insurance carrier, in lieu of reimbursing you directly, will pay to RCENT any benefits for services rendered. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.

It is your responsibility to consult with your insurance carrier regarding coverage for services provided by RCENT. Not all services are covered benefits in all plans, and we are not in-network with all carrier plans. Additionally, some services we provide will be billed separately from the office visit and may require a separate co-pay or be applied to your co-insurance/deductible. Please call your insurance company to verify your benefits. You will be responsible for all fees not paid by your insurance carrier.

Current Insurance Card: You are responsible for making available complete insurance information for accurate filing of claims. To meet this end, we will request your current insurance card at each visit.

Referrals: As a specialist, some insurance carriers require you obtain a referral from your primary care provider prior to any visit to RCENT. It is your responsibility to know if this is required by your insurance carrier and, if so, to obtain the referral. If this is not done by the day of your appointment, you will be responsible for all charges at the time of service, or you will have to reschedule your visit until a referral is obtained.

Medicare Assignment: (if applicable) I certify that the information given by me in applying for payment under Title S VIII and /or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services. I understand that I am responsible for my health insurance deductibles and coinsurance.

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(continued)

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Self-Pay Patients: Full payment is expected on the date of service, unless financial arrangements have been made prior to your visit.

Divorced/Separated Parents of a Minor Patient: The responsibility of payment for services rendered to any dependent patients, should parents be legally separated or divorced, rests with the parent who seeks treatment for the patient. Any court-ordered responsibility judgment must be determined between the individuals involved, without the inclusion of RCENT.

Supplies: Any supplies you receive from RCENT must be paid for in full at the time of service.

Outside Forms: Disability forms, FMLA forms, Leave of Absence forms, and other requested correspondence not associated with the reimbursement of a claim may incur a charge prior to completion of the form(s). Turnaround for form completion may vary with time and volume.

Missed or Late Cancellation of Appointment: If you miss or reschedule/cancel your appointment within 24 hours of the appointment, you may be charged $50. If you miss or reschedule/cancel your testing appointment within 48 hours (VNG)/72 hours (allergy) of the appointment, you may be charged $200. If you miss or reschedule/cancel a surgery within 7 days of the surgery, you may be charged $200. If you miss your appointment more than three times, you may be discharged from the practice. Fees will be collected at the time of the reschedule/cancellation.

Returned Check Fee: There is a charge of $40.00 to the patient in the event of a returned check for insufficient funds.

Unpaid Account Balances: We will mail a statement for any unpaid balance to the address you have provided once we receive payment from your insurance carrier. If payment for the account balance is not received within 30 days, a second statement will be mailed. If you fail to make payment after 60 day, your account may be turned over to a collection agency. You will be responsible for paying the collection agency's fees that may be incurred in the collection of any outstanding balance.

Financial Assistance: For patients with financial need, we offer extended payment plans. Please ask to speak with one of our billing office representatives to discuss your options.

Refunds: All refunds will be processed in the same manner, e.g., check, debit card, credit card, etc., as the original payment.

Agreement: I have read the above and agree to the terms stated.

_____
Patient Name

_____ _____
Signature of Patient or Legal Guardian Date