



Fort Collins
1120 East Elizabeth Street #F-101
Fort Collins, CO 80524
970-221-1177

Loveland
3820 North Grant Ave
Loveland, CO 80538
970-593-1177

FINANCIAL POLICY

Welcome to Alpine Ear, Nose & Throat. Please take a few minutes to review the following information prior to your appointment.

We hope you understand that our financial policies are established to assure the financial resources needed to maintain this medical office for all our patients. We will work with you to ensure that your medical care does not become a financial burden.

- Charges for medical services are due and payable at the time of service. We accept cash, personal checks, and visa and master card credit cards for payment of your account.
- Your insurance policy is an agreement between you and your insurance company. Our relationship is with you, and not with your insurance company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status.
- IT IS THE PATIENT'S RESPONSIBILITY TO KNOW THEIR BENEFITS. YOUR POLICY MAY APPLY ALLERGY TESTING/INJECTIONS, AUDIO TESTS, CONSULTATIONS, PHYSICAL THERAPY AND SCOPES TOWARDS YOUR DEDUCTIBLE; THEREFORE, IF YOU HAVE QUESTIONS REGARDING YOUR BENEFITS, IT IS IN YOUR BEST INTEREST TO CONTACT YOUR CARRIER DIRECTLY.

- OFFICE VISITS REQUIRE A 24-HOUR CANCELLATION NOTICE.
- PATIENTS WILL BE CHARGED A \$25 FEE FOR NOT GIVING NOTICE.
- TESTS REQUIRE A 48-HOUR CANCELLATION NOTICE.
- PATIENTS WILL BE CHARGED A \$75 FEE FOR NOT GIVING NOTICE.
- SURGERY CANCELLATIONS REQUIRE A 3-DAY NOTICE. PATIENTS WILL BE CHARGED \$250 FOR NOT GIVING PROPER NOTICE.

If you have health insurance with which we participate: Our receptionist can clarify whether or not we participate with your plan

- We will bill your insurance claim for you
- We expect any required co-payments or deductibles due at time of service

If we do not participate with your insurance plan:

- Payment is due at time of service and filing your claim is your responsibility

NOTE: If surgery is necessary, we will file your insurance claims as a courtesy to you

Accounts 30 days past due are subject to collection proceedings except when prior arrangements have been made with our business office. Please sign and date this form. Return to the Receptionist and she will provide you with a copy for your records.

I authorize Alpine Ear, Nose & Throat to furnish diagnosis and records of any treatment or examination rendered to me or my child during the period of such care to any or all of the following: Physicians involved in my treatment, Medicare, my insurance carrier (s), or my employer (for work related injuries).

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that Alpine charges a \$5.00/month statement fee for any balances that are not paid in full. I understand that if my co-payment is not made at time of service there will be a \$10.00 late fee for non payment.

I authorize Alpine Ear, Nose & Throat to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I have read and understand the above statement.

Date: _____ Signature: _____

Print Name: _____ Witness: _____