ENTAA Care
Ear, Nose & Throat, Asthma & Allergy
Audiology & Hearing Aid Center
Speech & Balance Center

INSURANCE AND SELF-PAY PAYMENT TERMS

Patient Name: _____ Date: ____/____/____

I hereby assign any and all insurance benefits due and payable to me by any policy of insurance or reimbursement plan to ENTAA Care P.A. ("ENTAA Care") for services rendered. I further understand and agree that this assignment is not revocable.

I understand and agree that without any required authorization or referral at the time of service from my third party payer, including, but not limited to, insurer, HMO, PPO or IPA, I may be financially responsible for any charges I incur. I will be financially responsible for any and all permitted charges not covered by my insurance benefits and personally guarantee all amounts owed to ENTAA Care. As the Personal Guarantor, I fully accept the medical services provided as full consideration for my signing this document. Certain conditions presented to our physicians may require a more thorough examination of a specific area accomplished through the use of an endoscope. In many cases, this examination can be accomplished quickly. A procedural fee will be submitted to your insurance carrier if this type of procedure is performed during your visit. In most cases we will accept your insurance company's allowance for this procedure. You will be obligated to pay any deductible and/or copayments/coinsurance that are applied by your insurance carrier. ***Please note - many insurance companies may list this diagnostic procedure as "surgery" and charges may be subject to your "surgical" benefits.***

If I am enrolled with an insurance company or third party payer health plan that does not have a contract with ENTAA Care and/or choose to self-pay for the services, I understand that payment in full for an evaluation and management exam and/or diagnostic exam and tests is due before the service is rendered. If additional services are rendered beyond the scope of the scheduled exam and/or tests, additional fees may be charged and payment in full is due at the time of check-out. If follow-up examination, treatment, testing, and/or review of diagnostic results are needed, these services are separately charged and payable at the time of service.

If I am enrolled with a third party payer or health plan, including, but not limited to a preferred provider organization, health maintenance organization, insurance company or provider network that has a contract with ENTAA Care, I understand that the services may be billed by ENTAA Care or its designee to my health plan and benefits will be determined at the time the claim is received. In that case, I will be financially responsible for payment of the coinsurance, co-payments, and deductible.

If any check to ENTAA Care from me for the payment of services is returned to ENTAA Care and is not paid for any reason, unless done so by fault of ENTAA Care, I agree to pay ENTAA Care a fee of $37.00. If any balances remain open and it is necessary for ENTAA Care to refer the account for collection, including returned statements for invalid or out-dated addresses, I agree to be responsible for all cost of collection, including attorney fees of fifteen percent (15%) of any balance due.

Effective January 1, 2009, ENTAA Care will be charging a $25 fee for failure to notify the office of a cancellation within 24 hours of your scheduled appointment time. This fee is ***not*** covered by your insurance company.

I have fully read and reviewed this document, and execute it with full knowledge and understanding of its contents.

_____ _____ ___/___/___
Signature of Patient if over 18 years of age Witness Date

_____ _____ ___/___/___
Signature of Guarantor Witness Date

_____
Guarantor's Relationship to Patient