



ENTAA Care

Ear, Nose & Throat, Asthma & Allergy
Audiology & Hearing Instrument Center
Speech & Balance Center

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. As the Personal Guarantor, I fully accept the medical services provided as full consideration for my signing this document. I will be financially responsible for all permitted charges not covered by insurance benefits and personally guarantee all amounts owed to ENTAA Care.

I have been made aware and understand that certain conditions presented to ENTAA Care physicians may require a more thorough examination of a specific area accomplished through the use of an endoscope. A procedural fee will be submitted to my insurance carrier if this type of procedure is performed during my visit. I understand that I will be obligated to pay any deductible, copayment, and/or coinsurance that are applied by my insurance carrier. *Please note – many insurance companies may list this diagnostic procedure as “surgery” and charges may be subject to your “surgical” benefits.*

If any check to ENTAA Care from me for payment of services is returned to ENTAA Care and is not paid for any reason, other than by fault of ENTAA Care, I agree to pay ENTAA Care a fee of \$37.00. Additionally, if any balance remains open and it is necessary for ENTAA Care to refer the account for collection, including statements returned 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.

I understand that I may be responsible for a cancellation fee of up to \$50 in the event that I am unable to make it to a scheduled appointment and I do not notify ENTAA Care of the cancellation within 24 hours prior to the appointment time. I further understand that this fee is not covered by my insurance plan.

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