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We are committed to providing you with the best possible care, and we 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 if you have any questions about our fees, Financial Policy, or your responsibility.

- You must have your insurance card with you for each appointment.
- Patients with insurance, with which we are participating/contracted with:
  - Copayments, deductibles, and co-insurance amounts are due at the time of service.
- Patients with Insurance that requires a referral from a Primary Care Physician:
  - Referrals must be in place on the date of service. Without this referral in place, full payment or rescheduling would be required. If no referral is in place, your options are as follows:
    - Reschedule your appointment.
    - Pay for the visit (minimum of $250). This money will be refunded to you as soon as a referral is obtained.
- Patients with no insurance or non-participating/contracted insurance:
  - Payment is due at the visit, upon your check in. For new patients, we require a minimum payment of $250. If the balance is different than this, upon your checkout, we will either set up a payment plan for you, or refund you the difference.
- Non Emergent Care will be denied if:
  - A minor under eighteen is unaccompanied by an adult.
  - A referral is not obtained when required by the patient's insurance, and the patient refuses to pay for the visit.
  - A patient has been delinquent on back payments and/or the account has been sent to a third party collections institution.
  - A patient has been previously discharged from the office.

I hereby authorize Mass ENT Associates to apply for benefits on my behalf for covered services rendered by them, or by their order. I request that payment from my insurance company and/or attorney, from PIP benefits or settlement proceeds, be made to Mass ENT Associates.

I understand that my insurance carrier may require a referral from my Primary Care Physician as authorization for treatment. It is my responsibility to obtain this referral. If a claim is denied by my insurance carrier for failure to obtain a referral, I will be held responsible for the full balance of the claim.

I permit a copy of this form to be used in the place of the original.

I have read and understand the conditions for payment to Mass ENT Associates and my responsibilities as outlined above.

Name:_____ Date:_____