



ENT and ALLERGY SPECIALISTS

FINANCIAL POLICY

Ear, Nose, & Throat

Sinus and allergy disorders

Sinus surgery

Sublingual immunotherapy

Sleep & snoring disorders

Radiofrequency & laser treatments

Head & neck surgery

Skin cancer

Speech & swallowing disorders

Ear disorders & surgery

Voice disorders

Balance disorders

Thyroid surgery

Pediatric ear, nose, & throat disorders

Audiology

Hearing evaluations

Hearing aids

Balance testing & treatment

Newborn hearing screening

Facial Plastic/Cosmetic

Facial plastic surgery

Non-invasive facial treatments

Botox/Restylane

Laser skin resurfacing

Hair removal

Skin care

Laser vein therapy

www.ENTandAllergySpecialists.com

Dear Patient:

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to contact our billing office at (610) 415-1100.

We ask that all patients read and sign our Financial Policy and HIPAA form as well as complete our Patient Information Form and Consent Form prior to having your examination, therapy, and/or study. Medicare patients are required to sign an ABN.

All insured patients are required to sign the assignment of benefits for payment from the insurance company. We will submit your claim to the insurance company on your behalf but if the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier. You will be billed for any non-covered services, deductibles, co-pays, and/or co-insurance.

It is the responsibility of the patient to ensure any referrals, precertification or authorizations have been obtained prior to your appointment. In the event your plan procedures are not followed prior to your appointment, your appointment may be rescheduled.

Delinquent accounts will be turned over to collection agency with a 2 weeks notice unless demographic information has changed and returned to us by the United States Postal Service. Accounts will be considered delinquent if unpaid after 60 days. In the event your account is turned over for collection, you will be responsible for all reasonable collection and court costs at the time the account is considered delinquent.

Again, thank you for choosing us as your health care provider. We appreciate the opportunity to serve you.

Patient Signature: _____
(if over 18 years of age)

Assignment of Benefits

I hereby guarantee payment of all charges incurred at the office of ENT and Allergy Specialists. I hereby assign and direct to pay any and all benefits for medical services under this claim directly to ENT and Allergy Specialists. I hereby authorize the release of any medical information requested by the insurance companies.

Patient Signature: _____
(if over 18 years of age)

7/2/11

Lionville
255 Gordon Dr, Suite 101
Lionville, PA 19341
T 610.524.5300
F 610.524.0100

Phoenixville
826 Main St, Suite 201
Phoenixville, PA 19460
T 610.415.1100
F 610.415.1101

Bryn Mawr
1201 County Line Rd, Suite 101
Bryn Mawr, PA 19010
T 610.520.0900
F 610.520.0920

Pottstown
5 South Sunnybrook Rd, Suite 300
Pottstown, PA 19460
T 610.326.3600
F 610.326.4466

Roxborough
525 Jamestown Ave, Suite 205
Philadelphia, PA 19128
T 215.487.7200
F 215.487.7201



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Please advise us if there has been a change in your address, phone number, or insurance coverage since your last appointment.

If you are unable to keep your appointment with the doctor and do not give 24 hours notice a fee may be charged.

If you are unable to keep your procedure or testing appointment and do not give 48 hours notice a fee may be charged.

Payment is expected as services are rendered unless prior financial arrangements have been made.

If co pay is not paid at time of visit, there will be a charge of \$11.50 for administrative costs.

A fee of \$25.00 will be charged for all returned checks.

There will be an administrative fee for the completion of all forms.

Patient Signature: _____
(if over 18 years of age)

Date: _____

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