

Wilkinson Snowden Otolaryngology Consultants

AUTHORIZATIONS AND ACKNOWLEDGEMENTS

We are committed to providing you with the best possible care, and we are please to discuss our professional fees with you at any time. Please ask us if you have any questions about our fees, financial policy, or your payment responsibility.

All new patients will be asked to provide patient information prior to being seen by the physician. We also may ask to make a copy of any type of picture identification to remain a permanent part of your chart.

INSURANCE INFORMATION

- ?? If you are covered by Medicare or any of our managed plans, we will file your insurance claim. You are responsible for any co-pay, co-insurance, deductible, or non-covered services at the time of our visit. If we do not participate with your insurance company, you will be responsible for full payment at the time of your visit.
- ?? All self pay patients are expected to pay for services in full at the time that services are rendered.
- ?? In the event your insurance company does not pay the full balance within 90 days, we will notify you so that you may contact your insurance carrier. Please remember that ultimately payment responsibility rests with the patient. Please advise our office personnel of any changes in your insurance or mailing address.
- ?? Should it ever become necessary to use the services of a collection agency to collect your account, you would be responsible for any costs incurred for that purpose.

UNACCOMPANIED MINORS

The parents (or guardians) will be responsible for full payment unless covered by a participating managed plan. Authorization to treat an unaccompanied minor must be on file.

COMPLETION OF FORMS

Wilkinson Snowden Otolaryngology Consultants reserves the right to charge a nominal fee for the completion of disability and/or Family Medical Leave forms.

I hereby authorize Wilkinson Snowden Otolaryngology Consultants to bill my insurance company directly for these services. I understand I am financially responsible for charges not covered by my insurance company. I authorized any holder of medical or other information about me to release to the Social Security Administration or intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits either to myself or to the party who accepts assignment. I certify that the insurance information is currently correct.

Responsible Party Signature

Patient's Name (Please Print)

Birth Date

Date

NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of a copy of the Wilkinson Snowden Otolaryngology Consultants (WSOC) Notice of Privacy Practices (NPP) either at this time or previously, By accepting services at WSOC, I authorized WSOC to use and disclose information from and release copies of my (the patient's) medical records in accordance with WSOC's policies and privacy practices, which are summarized in the NPP, including disclosure to my (the patient's) past, present and future healthcare providers.

PATIENT or PARENT (GUARDIAN)

METHODS OF PAYMENT

CASH, CHECK, VISA AND MASTERCARD