FINANCIAL POLICY AND AGREEMENT FOR ATLANTIC OTOLARYNGOLOGY

Atlantic ENT LLC
333 W Cocoa Beach CSWY, Ste. B
Cocoa Beach, FL
32931-3513
Tel 321-799-9797

We find that communication with our patients helps us in providing the best service to you. We have taken the time to provide information about the most commonly asked questions.

PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED;
We accept cash, personal checks, and major credit cards (MasterCard, Visa). Returned checks are subject to a service charge of $ 20.00 and you will lose your privilege to write a check to our office. Credit card payment are subject to a 2% service charge.

REGARDING INSURANCE:
The doctor service is provided directly to you and not to an insurance company. We cannot render service on the assumption that charges will be paid for you by the insurance company. If we participate with your insurance, we will file your services directly to them. You will be expected to pay any deductible and or co pay as outlined in your policy when you check in on your appointment day.

AUTHORIZATION FOR SERVICES:
The patient is responsible for all authorizations for services before services are rendered. If we do not have an authorization number at the time of your visit, you can either pay for services or reschedule your appointment. Patients are also responsible for letting us know which lab their insurance requires us to use for any laboratory work.

SPECIAL NEEDS:
Special needs are understood by this office. It may be necessary to setup a payment plan for a patient requiring extensive treatment. If this situation arises, please bring it to our attention prior to treatment or as soon as possible. We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. All charges are your responsibility from the date services are rendered. If we do not participate with your insurance company, but file as a courtesy, we expect payment from either your insurance company or from you within 30 days. You must then collect from your insurance company if they did not pay.

Thank you for taking the time to read this policy statement. We hope it answers your questions. If you have more, please let us know.

I have read and understand the above financial policy and agree to the terms as stated;

_____ _____
Patient Name (Please Print) Patient/Guardian Signature

Date _____