

MECKLENBURG EAR NOSE AND THROAT

Patient Financial Responsibility Agreement

As a patient of Mecklenburg Ear Nose and Throat, you are hereby agreeing:

- **To Pay all non-insured charges**, including your co-pay, co-insurance, insurance deductibles and all other non-covered charges at the time of service or at least 2 days prior to any surgical procedure that will not be done in our office.
- **To provide us with a copy of your most recent insurance card**, or other proof of insurance at the time of EACH visit. If you do not provide us with valid insurance information at the time of EACH service, you agree to personally pay all unpaid charges. Any **new** patient who is not able to present us with a valid insurance card will be responsible for the cost of the visit at the time of service.
- **To obtain any authorization required by your insurance plan for our services** from your Primary Care Physician and/or your insurer prior to each appointment. If you do not receive the required authorization, your insurer may not pay us for our services. In these cases you agree to personally pay any resulting unpaid charges. Any **new** patient who does not have authorization will be responsible for the cost of the visit at the time of service.

Further, you agree that your physician and Mecklenburg Ear Nose and Throat has the right to be paid for their services and you acknowledge:

- That unpaid bills older than 90 days from date of service may be turned to a debt collection agency or attorney for collection along with administrative fee.
- That you will be responsible for any resulting collection fees, including reasonable attorney fees, and/or bank fees incurred as a result of a returned check.

Patient or Guarantor

Signature _____ **Date** _____

By my signature, I am indicating that I have read, understand and agree to the above provisions.