



PRACTICE FINANCIAL POLICY

Thank you for choosing Ear, Nose & Throat Specialist of Illinois as your health care provider. Your understanding of our financial policy and payment for services is an important part of this relationship.

Insurance is a contract between you and your insurance company. It is the patient's or guardian's responsibility to understand the benefits and requirements of their insurance plan, including whether our physicians are in network. We will file claims on your behalf; however, you must provide all insurance information—primary, secondary and any updates or changes. Not all plans cover all services, and if your insurance determines a service is **not covered**, you are responsible for the full charges.

SELF PAY: Self-pay patients must provide a \$100 appointment deposit to secure their scheduled visit. This deposit is non-refundable if the appointment is canceled with less than 24 hours' notice or if the appointment is missed. Full payment for all services is required at checkout on the day of the appointment.

INSURANCE PAYMENTS:

1. All co-payments, deductibles, patient responsibility amounts and past-due balances are required to be collected at the time of service. If our physician is not contracted with your insurance plan, you are required to remit FULL PAYMENT at the TIME OF YOUR VISIT.
2. **HMO insurance** REQUIRES A PCP REFERRAL or insurance authorization to see the providers at ENT OF IL. If you fail to present the referral, your appointment will be rescheduled. If you still prefer to be seen, we will collect full payment at your visit.
3. Fees for any procedures, such as **nasal endoscopy, ear cleaning, audiological testing, etc.**, are NOT included with the office exam and may be applied to your deductible or co-insurance depending on your insurance.
4. Medicare Part B has a calendar year deductible and a 20% co-insurance. Secondary insurance may or may not cover your Medicare annual deductible. The patient is responsible for this balance.

Once we receive payment from your insurance company, you will be billed for any remaining balance assigned to you, including co-payments, deductibles, co-insurance or non-covered services. A statement will be posted to your patient portal and mailed to your address on file.

CREDIT CARD ON FILE POLICY

It is the policy of Ear, Nose & Throat Specialists of Illinois, LTD, to collect and securely store a credit card on file for each patient to cover the patient's responsibility portion of their bill. Explanations of Benefits (EOBs) are sent to both our office and to you, outlining the amount you owe. If payment is not received within 30 days of the statement date, the card on file will be charged for any outstanding balance unless prior arrangements have been made.

1. ENT Specialists of Illinois accepts Visa, MasterCard, Discover and American Express. If you provide a debit card, please note that any charges will be withdrawn directly from your bank account. Your card information is encrypted, not visible to staff and stored in a high-level security system that exceeds HIPAA and Payment Card Industry (PCI) compliance standards.
2. If your card expires, you are expected to provide updated payment information promptly. Accounts with an outstanding balance for more than 90 days will be sent to an outside licensed collection agency.

FINANCIAL ARRANGEMENTS/PAYMENT PLAN: Each patient is required to establish financial arrangements within 30 days of the statement date or pay the balance in full. If you need to discuss a payment plan, please contact the Billing Department at 847-674-5585 and select option 5.

CANCELLATION OR MISSED APPOINTMENTS: At least 24 hours' notice is required to cancel or reschedule an appointment. Failure to provide notice or a no-show will result in a missed appointment fee.

I have read, understand and agree to the above Financial Policy. I understand my financial responsibility to make payments for services provided to me and hereby authorize my insurance benefits to be paid directly to the physician's office. I understand that I am responsible for paying for non-covered services. I further authorize the release of pertinent medical information to my insurance carriers. I authorize ENT spec of IL, Ltd, to charge my card for the balance due. A photocopy of this assignment shall be considered as effective and valid as the original.

Print Name _____ DOB _____ Patient /Guardian Signature _____

Name on Credit Card _____ Cardholder Signature _____ Date _____