

# FOOTHILLS EAR, NOSE AND THROAT

201 Richard Street, Easley, South Carolina, 29640 864/859-1912 Fax 864/855-9836  
10 Enterprise Blvd., Suite 201, Greenville, South Carolina 29615 864/234-7815 Fax 864/234-7846

## FINANCIAL POLICY

1. Medicare, Workers' Compensation & Commercial Insurance will be filed with your insurance carrier. If you have an HMO or PPO Plan in which we are providers, you must pay your co-insurance amount at the time of your appointment. Co-insurance includes your copay and/or your percent of the allowable as determined by your insurance carrier
2. If your HMO or PPO insurance carrier requires written authorization for referral to a specialist, you must bring the authorization with you for your appointment. Without the authorization, your appointment will have to be rescheduled.
3. We will file your secondary insurance as a courtesy. However, you are responsible for your copay and/or the percent of the allowable as determined by your insurance carrier.
4. If your insurance carrier is not a carrier that we have a preferred provider contract with, we will not accept their "Usual and Customary" fees. Usual and Customary fees are determined by the individual insurance company. Our fees reflect the Usual and Customary charges for this area. However, our fees may vary slightly from the Usual and Customary fees cited by insurance companies, which often include non-specialist fees and outdated fees in their computations.
5. If this is a liability claim, payment of the account is the responsibility of the individual who has received the treatment, not the individual who is being sued. For this reason and the fact that liability claims may go on for an extended period of time, we require our fee to be paid at the time of service.
6. Patients without insurance coverage will be required to pay for service in full at the time of service. This includes patients with liability insurance claims.
7. If you require surgery, a patient representative will provide you with the estimated fee and explain your expected financial obligation after your insurance has paid their portion of the fee. We require payment of your expected financial obligation prior to the procedure.
8. If you have been seen by one of our physicians in the past and have a past due balance, the balance must be paid prior to your visit.
9. A fee is charged to complete disability/medical forms. We ask that you complete the patient-portion of the forms and submit them to our office as soon as they are received. Please allow one to two weeks for completion of the forms.
10. There will be a \$25.00 service charge for all returned checks.

My signature below indicates that I have read the Financial Policy as states above and understand that I am responsible to the physician for all charges that I incur.

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

(Or) Guardian's Signature \_\_\_\_\_ Date Signed: \_\_\_\_\_