E.N.T. SURGICAL ASSOCIATES OF CENTRAL GEORGIA, P.C.

OTOLOGY
RHINOLOGY
LARYNGOLOGY
ALLERGY

1719 RUSSELL PARKWAY
McNEAL CENTER - BUILDING 300 - SUITE 301
WARNER ROBINS, GEORGIA 31088
(478) 923-0106

FACIAL PLASTIC
SURGERY
HEAD AND NECK
ONCOLOGY

Authorizations and Financial Policy

Authorization for Treatment: I present myself or child for whom I am guardian for evaluation, and treatment or surgical procedure(s) that may be ordered or required during my treatment by Dr. Toland, his assistants, or his designee and authorize any emergency medical care. I understand that the practice of medicine is not an exact science and that NO GUARANTEE OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of any procedure or treatment as a result of the examination by ENT Surgical Associates, ENT Surgical Center, Dr A. Daniel Toland or Erin Burch, R.N, MSN, FNP-C.

Billing for ENT Surgical Center: I understand that by having services provided by **ENT Surgical Associates and ENT Surgical Center** that I will be billed for the facility. I accept full responsibility for both accounts that I will have with Dr. Toland. I understand that I am responsible for any monies no payable to ENT Surgical Center outside the allowable fee schedule agreed upon by my insurance(s) and ENT Surgical Center. *****Our Center may be out of network with your insurance company, but it will be treated as an in network facility. In most instances, your insurance company will be mailing the payment for services rendered by Dr. Toland and/or the ENT Surgical Center to the insured party. Remember that these monies are for the surgical services already performed and we are obligated and will ask for prompt payment once you receive payment. ***** I fully understand that any payments mailed to the insured party are my responsibility and I will remit the payment to the ENT Surgical Center upon receipt of the payment.

Medicare/Medicaid Patient's Certification: I certify that the information given by me in applying for payment under Title XVII and XIX of the Social Security Act is correct. I request payment be made directly to the provider of services on my behalf and I authorize said provider to release any and all information necessary regarding the treatment and services provided as stated below.

Assignment of Benefits: I hereby authorize payment directly to ENT Surgical Associates or ENT Surgical Center by my insurance company(s). In the event an overpayment is made from more than one insurance company, I understand the overpayment will be sent to the appropriate payer.

Surgery Services Provided: I hereby understand that all ENT Surgical Associates and ENT Surgical Center surgery procedures are to be paid in full before services are rendered. In the case that the patient is self-pay, payment can be made with credit card, money order, or cash. **In order to pay for surgery by check, payment must be presented at least 10 days in advance to the office.**

Insurance: ENT Surgical Associates and ENT Surgical Center will file your insurance as a courtesy to you. If our office does not hear from your insurance company within 30 days, we request your help in contacting your Insurance Company to resolve the payment delay. The Insurance plan is a contract between you and your Insurance Company. We must hold you responsible for any balance due.

(Over)

Referrals: I understand that my insurance may require an authorization before services can be rendered. I hereby agree to obtain any referrals and authorizations for any visits necessary. I hereby understand that any services rendered without a referral authorization will in turn be my financial responsibility.

Payment of Services: I understand I am financially responsible for all charges and fees related to the services rendered to me by ENT Surgical Associates and ENT Surgical Center. I understand that all co-pays and deductibles are due at the time of service. I further understand that payment in full is expected upon receipt of the first statement and/or prior to additional office visits; this may include co-payments, additional deductibles and any services not covered by Insurance. I further understand that all post-dated checks will not be accepted. I also understand that if I am self-pay that payment is due on the date of service.

Fees: I understand the ENT Surgical Associates and ENT Surgical Center may charge $ 30.00 or 5% of the face amount of the instrument; whichever is greater, in addition to any institutional fees for a returned check. I further understand that if payments are not made as stated I agree to pay all reasonable legal fees and costs of collection to the extent permitted by law. I also agree that this contract cannot be substituted by and Debt Management Program proposals.

Patient/Guardian Name (please print): _____

Signature _____ Date _____

Witness _____ Date _____