FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and regard your understanding of your financial responsibilities an essential element of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

- **APPOINTMENTS** – We request 24 hours notice in the event you cannot keep an appointment, otherwise, a cancellation fee of $25 may be added to your account.

- **INSURANCE** – We will file your insurance claims for you. You will be responsible for any deductible, co-insurance, and services not covered by your insurance plan. If additional tests are required as part of your examination, you will be billed separately for any services provided by the facility, anesthesiologist, laboratory and radiology.

  Please remember that your insurance policy is a contract between you and your insurance company. While we will assist you by filing your claims, you will be responsible for any balance your plan indicates as due on their explanation of benefits form. If your insurance company has not paid a claim within six months from the date of service, you will be responsible for the full amount due. Should you receive payment from your insurance carrier; please forward it to our office.

  Lifetime Private Insurance Authorization for Assignment of Benefits/Release of Information: I, the undersigned, authorize and direct my health insurance company, or self-insured plan, to make payment of medical benefits to Midwest Sinus-Allergy Specialists for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- **CO-PAYMENTS** – By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit**. ALL** RETURNED CHECKS WILL HOLD A $25 RETURN FEE.

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

- **MEDICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which we will file to a secondary insurance if you have one.

  Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Midwest Sinus Allergy Specialists for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information needed to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

  I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the named Medigap insurer any information needed to determine benefits payable.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The parent who consents to the treatment of a minor child is responsible for payment of services rendered, Midwest Sinus Allergy Specialists will not be involved with separation or divorce disputes.

- **FMLA PAPERWORK** – Family Medical Leave Act paperwork can be completed by our providers for a $35 fee per application.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, OR DISCOVER CARD.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name: _____ Patient's DOB: _____

Responsible Party Signature: _____ Date: _____

Print Name: _____ Relationship: _____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA), I have certain rights to privacy regarding my protected health information. I have been informed by the office of Midwest Sinus Allergy Specialists that the *Notice of Privacy Practices* is available in the waiting room for my review.

By signing below, I acknowledge that I have been provided with an opportunity to read the Midwest Sinus Allergy Specialists' *Notice of Privacy Practices* and have therefore been advised of how health information about me may be used and disclosed. I further understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party providers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that information will not be discussed with any other person(s) unless authorized below. I hereby authorize the following individual(s) to receive information regarding my medical condition(s):

_____ _____

_____ _____

Patient's Name: _____ Patient's DOB: _____

Responsible Party Signature: _____ Date: _____

Print Name: _____ Relationship: _____