

Financial Policy

Thank you for choosing us as one of your health care providers. We are dedicated to providing you with quality care and efficient service. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. Your understanding of our financial policy is essential. If you have any questions regarding any aspect of our policy, please ask us.

We accept Visa, MasterCard, Discover, American Express, Health Savings Accounts, cash or check. You may make a payment anytime online at www.nkyent.com.

Insurance

Though we file insurance claims as a courtesy to our patients, all charges are ultimately the responsibility of the patient/guarantor as of the date the services are rendered. Please understand that not all services are covered by all insurance carriers. It is thus highly recommended that patients communicate with their insurance companies to understand their benefits and limitations to their benefits. When services are not covered by insurance, or if services are being provided on a self-pay basis, full responsibility remains with the patient/guarantor.

Referrals

Some insurance companies may require a referral. It is the patient/guarantor's responsibility to obtain the referral prior to the time of service. When required, the patient/guarantor will be responsible for payment in full at time of service if a required referral is not provided.

Co-pays and Past-Balances

All co-pays and all past-balances are due at the time of service. New self-pay patients are required to pay a \$150.00 payment at the time of service and any Established patients are required to pay \$50.00 at the time of service with any remaining balance due upon receipt of statement.

Deductibles & Coinsurance

If you have a deductible and/or coinsurance, you are required to pay 50% of your estimated charges at your office appointment or 24 hours prior to surgery. Any remaining balance is due upon receipt of a statement.

If your balance is not paid, it will be automatically placed with a professional collection agency and reported to the credit bureau. If this occurs, you will be responsible for collection fees, interest and attorney costs.

Contact

Important note: By providing a cell phone number as your contact number, you consent to receiving automated or prerecorded appointment reminder calls, important calls, and/or text messages on your cell phone. Your cell phone carrier's standard rates may apply for calls or text messages to your cell phone. If you would like us to utilize a different number—please provide that number instead of your cell phone number. You may revoke your consent at any time by calling 859-781-4900.

I have read and fully understand the financial policy set forth by ENT & Allergy Specialists and Center for Surgical Care. I agree to the terms of this financial policy. I authorize my insurer to pay any benefits directly to ENT & Allergy Specialists and Center for Surgical Care. I agree to pay ENT & Allergy Specialist and Center for Surgical Care the full and entire amount of all bills incurred by me or the patient named below including if applicable, any amount due after payment has been made by my insurance carrier. I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately financially responsible to ENT & Allergy Specialists and Center for Surgical Care for any services rendered. I also understand and agree that the terms of this financial policy may be amended by the practice at any time.

Print Name	Signature	Date
If Patient is a Minor Under Age 18: Print Patient Name	Relationship to Patient of Person Signing	