Ear Consultants of Georgia, P.C.

OFFICE POLICY REGARDING HEALTHCARE INSURANCE

In order to accommodate the needs and requests of our patients we have enrolled in many managed insurance programs.

While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all of the individual requirements of the plans. Each one has different stipulations regarding how often services may be rendered and, even more importantly, where those services may be performed. These requirements also change from time to time.

Even with the same insurance company the plans differ depending upon what type of contract you employer has negotiated.

Providing quality medical care for our patients is our primary concern. We are willing to provide that care within your insurance contract guidelines if you let us know at each time of service what those guidelines are.

It is your responsibility, as the patient/insured, to be aware of the current terms of your insurance coverage. All co-pays, by contract, must be paid at the time of your visit. If your yearly deductible has not been met, this must be paid at the time of your visit. We collect that before you see the doctor. If you do not have your co-pay/co-insurance at that time, you will need to reschedule your appointment. If you do not have insurance, or insurance we participate with, payment is expected at the time of service. For your convenience we accept cash, check, Visa, and MasterCard.

If you participate in an insurance plan that requires you to have a referral for your visit, you must coordinate getting that referral through your primary care physician prior to your appointment. Patients without valid referrals will be rescheduled or will be responsible for payment at the time of service.

Unfortunately, if you do not inform us of any special requirements in your contract and we subsequently order services, such as lab work or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

In the event that services are provided and your coverage is not in effect on that day, then the fees submitted and denied by your carrier will become your responsibility.

With your cooperation and help, you should be able to receive all of the benefits offered to you, and we will be able to concentrate on caring for your medical needs.

I have read and understand the office policy stated above and agree to accept responsibility as described.

____   ________________________

Patient and/or insured   Date

Ear Consultants of Georgia

Pre-Certification Policy

Ear Consultants of Georgia has adopted the following policy for pre-certification on all insurance plans, health maintenance organizations, other reimbursement plans, excluding Medicare:

1. When provided with complete insurance information at admission, we will assist patients in pre-certifying their admission and stay as directed by their insurance company. Patients should contact their employer if they are unsure of their policy requirements regarding pre-certification.

2. Regardless of the outcome of pre-certification efforts, Ear Consultants of Georgia will NOT be financially responsible for any reduction in payment or any penalty sustained by the patient or guarantor. Nor will Ear Consultants of Georgia accept the responsibility for pre-certification. Any failure of Ear Consultants of Georgia personnel to assist in this process will NOT make Ear Consultants of Georgia financially liable.

3. Ear Consultants of Georgia will hold the patient, or guarantor, responsible for all balances not paid by the patient's insurance company, HMO, or other reimbursement plan, regardless of the conditions of pre-certification, or the outcome of the process.

4. Ear Consultants of Georgia acknowledges the pre-certification process may often be a complex and labor intensive exercise. With a vast multitude of insurance companies, insurance plans within the insurance companies, and other less traditional reimbursement plans, it is the patient's and/or the gurantor's responsibility to know the requirements of his policy. As the owner of the policy, it is imperative the guarantor understand all of the parameters of the plan he owns. Accordingly, Ear Consultants of Georgia will not be held financially responsible when the plan requirements are not fulfilled to the satisfaction of ANY third party payor.

Ear Consultants of Georgia, P.C.

Patient Information – Confidential

Thank you for choosing this office!

What is the Reason for your visit today? ____

Who may we thank for referring you?____

Date ________________________ **Patient Account #** ____________________**[Office Use Only]**

Patient Name ____ Check appropriate box: ▯ Male ▯ Female

SSN _______________________________ Birthdate _________________________ Age ______________________

Address ___________________________________ City ______________________ State _________ Zip __________

Prim. phone ____________________ Sec. phone _____________________ Email Address _______________________
(cell, home, office) *(cell, home, office)*

Preferred Method of contact (please circle one): Voicemail Text message Email

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient's Employer ____ Work phone __________________________

Address ________________________________ City ________________________ State _________ Zip __________

Occupation ______________________________ Driver's license # ____

Spouse's name _________________________ Employer __________________________ Work phone _____________

Person to contact in case of emergency ____ Phone _________________

Responsible Party (if patient is a minor)

Person responsible for this account _______________________________ Relationship to patient ___________________

Address _______________________________ City ________________________ State _________ Zip __________

Home phone _______________________________ Driver's license # ______________________________________

Birthdate __________________________________ Social Security # ______________________________________

Employer ____ Work phone _______________

Employer address _____________________________ City _______________________ State ________ Zip _________

Insured Party Information (policy holder)

Name of insured ____ Relationship to patient ____________________

Birthdate _________________ Social Security # ______________________ Date employed _______________________

Employer ____ Work phone _________________________

Employer address ______________________________ City ______________________ State ________ Zip _________

Insurance company ________________________ ID # ___________________________ Group # ________________

Insurance co. address ____________________________ City ______________________ State ________ Zip ________

How much is your office visit co-pay/co-insurance? ________________________________ Group name _____________

Ear Consultants of Georgia, P.C.

Patient Name ________________________ Birthdate _____________________ Patient # ___________

Do you have additional insurance? Î Yes Î No If yes, complete the following:

Name of insured ____ Relationship to patient ___________________

Birthdate ________________ Social Security # _____________________ Date employed ______________________

Employer ____ Work phone ________________________

Employer address ____________________________ City ______________________ State _______ Zip _______

Insurance company ______________________ ID # __________________________ Group # ________________

Insurance co. address __________________________ City ______________________ State _______ Zip _______

How much is your office visit co-pay/co-insurance? _______________________________ Group name ______________

Worker's Compensation Information

Is this a worker's compensation claim? □ Yes □ No if yes, complete the following:

Employer contact ____________________________________ Employer phone # ___________________________

Worker's Comp contact ________________________________ Worker's Comp phone # _______________________

Date of Injury? _______________________ Description of Injury ____

[Office Use Only] Claim # _______________ Worker's Comp Carrier _________________________________

Worker's Comp Carrier Address____

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Procedure for Filing Claims ____

Authorization & Release With this signature, I hereby authorize Ear Consultants of Georgia, P.C. to release any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. Furthermore, I understand that regardless of insurance, I am ultimately responsible for payment of fees for professional services rendered, including non-covered services. If my insurance company (ies) changes at any time, I am responsible to notify this office and provide a written copy or I will be ultimately responsible for payment of fees for professional services rendered at that time.

____ _______________________________________

Signature of patient (or parent or legal guardian) Date

Late Charges and Collections Fees All payments for services provided by this practice are due and payable at the time services are rendered, or within 30 days of the patient receiving the invoice for such services. In the event payment is not received as described above, a late payment fee of 1.5% per month will be charged. In addition, in the event that any bill goes to collection, patients will be charged all costs associated with collection, including reasonable attorney fees.

____ _______________________________________

Signature of patient (or parent or legal guardian) Date