Name:
DOB:
Date:

Greenville ENT
Financial Agreement

Lifetime Signature on File (for Medicare patients)

I request that payment of authorized Medicare benefits be made on my behalf directly to this practice for any services furnished to me by the physician. I authorize the release of any medical or other information necessary for processing claims to the Center for Medicare and Medicaid Services. (CMS) Initials: __________________________

Diagnostic Services

Our physicians are Board Certified and use the latest diagnostic technologies to effectively diagnose and treat problems of the ear, nose, and throat. For example, patients with sinus problems may have a nasal endoscopy procedure performed at their visits to effectively diagnose sinus issues. I understand I may undergo diagnostic testing for a complete ENT evaluation.

Initials: __________________________

Minor Procedures

Services rendered today by the physician are reported to your insurance carrier using a coding system known as CPT (Current Procedural Terminology). There are times when the provider determines it necessary to perform a procedure that is NOT considered part of the office visit, and the provider is required to bill this service in addition to the Evaluation and Management (Office Visit) code using the appropriate CPT Codes. Per CPT guidelines, any procedure performed in the office today will be billed using the appropriate CPT code in addition to the Evaluation and Management code (Office Visit) and may be reflected on you Explanation Benefit that you receive from your insurance company as a “surgical procedure”. As such, your insurance company may apply a surgical co-insurance, co-pay or deductible per your insurance plan guidelines in addition to any office visit co-payment. Be assured that we are following accepted billing and coding guidelines and that all procedures/tests are performed in the best interest of patient care. Initials: __________________________

Examples of these services are:

Binocular Microscopy	Mastoid Cavity Debridement	Video Stroboscopy
Endoscopic Nasal Exam	Removal of Impacted Cerumen	Tympanic Membrane Patch
Removal of Foreign Body	Flexible Fiberoptic Laryngoscopy	

Authorization to Release and/or Obtain Medical Records

I hereby authorize all physicians participating in my health care, and Greenville ENT physicians, the release, use and disclosure of my entire medical record by mail, phone, and fax, to carry out my treatment, payment, and healthcare operations.

Initials: __________________________

Minor Patients

I understand that patients under the age of 18 must be accompanied by the parent or guardian. The parent who consents for treatment will be the responsible party on the account and is responsible for all charges regardless of divorce or separation decree. We request patient age 18 or older covered under their parents’ insurance to sign an authorization allowing Greenville ENT to contact parent regarding insurance and billing issues. Initials: __________________________

Financial Agreement

I understand that I am financially responsible for all charges incurred at Greenville ENT. A service charge of $30.00 may be applied to my account in the event it becomes delinquent or assigned to an outside collection agency.

Initials: __________________________

I understand that the authorization for release of information will be valid until revoked upon written notice. By signing below, I acknowledge that this form has been read in full and explained as necessary.

____ _________________________________

Signature of Patient/Responsible Party **Date**

_____________________________________ _______________________________ _________________________________

Responsible Party SSN **Responsible Party DOB** **Relationship to Patient**