



ENT MEDICAL SERVICES
SLEEP CENTER, PLC
2901 Northgate Drive
Iowa City, IA 52245
319.338.2101 / 319.338.1973 Fax

FINANCIAL POLICY:

This agreement is between ENT MEDICAL SERVICES SLEEP CENTER, PLC as **creditor** and the **patient/guarantor** named on this form. By executing this agreement, you are agreeing to pay for all services that are received.

It is your responsibility to know the requirements of your insurance company. This includes participation, referral requirements, second opinion, prior approval, pre-certification and out-patient and / or in-patient status. **You are also responsible for all CO-PAYMENTS, CO-INSURANCE AND INSURANCE DEDUCTIBLE REQUIRED by YOUR INSURANCE PLAN.** You must be aware of any pre-existing conditions or waiting periods outlined by your insurance carrier.

MONTHLY STATEMENTS: If you have a balance on your account, we will send you a monthly statement. It will show current balance, insurance adjustments/payments and monthly interest on balances over 60 days. Unless other arrangements are approved by ENT MEDICAL SERVICES SLEEP CENTER, PLC in writing, **the balance in full on your account is due and payable within 60 days from the date of service.**

INSURANCE: Insurance is a contract between you and your insurance company. We are not a party to this contract in most cases. We gladly submit your claims and will assist you in receiving the maximum benefit from your plan. All plans, however, have limitations and some may not cover 100% of the fees for our services. If your insurance company requires a referral and/or preauthorization, **you** are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in lower or no payment from the insurance company. Please remember that although we will assist you with your claim, you must assume full responsibility for payment.

DIVORCE: In the case of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for the subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

UNINSURED PAYMENT OPTIONS: Payment is required in full from the date of service, unless other arrangements have been made, in writing, with ENT MEDICAL SERVICES SLEEP CENTER, PLC. 15% discount will be taken if balance is paid in full on the date of service.

EXTENSIVE TREATMENT and/or LARGE BALANCES: We understand that medical bills can add up quickly and sometimes patients aren't able to pay the balance in full within the 60 days. We would suggest trying to secure a bank loan for balances over \$1000.00, as we are unable to extend credit for long periods of time. Other options include monthly payments with check, credit card, or money order with interest of **1.5% monthly or 18% annually.**

WORKERS COMPENSATION: We require written approval or authorization by your employer and/or worker's compensation carrier **PRIOR** to your initial visit. If your claim is denied, you are responsible for payment in full.

PAST DUE ACCOUNTS: If your account becomes past due, we will take necessary steps to collect this debt, which could result in turning your account over to a collection agency or an attorney.

Suggested Monthly Payments:

\$0 - \$50	Payment in full
\$50 - \$150	2 monthly payments
\$150 - \$300	3 monthly payments
\$300 - \$500	4 monthly payments
\$500 - \$2000	6 monthly payments
\$2000 - \$3000	12 monthly payments
\$3000 - \$5000	18 monthly payments
\$5000 - \$Above	24 monthly payments

PAYMENT OPTIONS:

CASH

CHECK

CREDIT/DEBIT CARD

MONEY ORDER

CareCredit®, FOR THIS OPTION PLEASE SPEAK TO A BILLING REPRESENTATIVE

A monthly finance charge of 1.5% or **(18 % annually)** will be added to balances over 60 days if unpaid.

Required Payments: ALL co-payments must be paid at time of service.

Failing to pay co-pays and deductibles could result in loss your insurance coverage.

We understand there will be some exceptions to these policies and are willing to work with you whenever possible.

EFFECTIVE DATES: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name _____ Date: _____

Responsible Party

IF NOT THE PATIENT

Signature _____ Date: _____

Co-Signature (If required) _____ Date: _____