



David S. Oliver, MD, FACS, FAAAA

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Patient Financial Policy

Welcome, and thank you for choosing Coastal Ear, Nose & Throat. Your clear understanding of your Patient Financial Policy is important to our professional relationship. Carefully review the following information and return this form with your signature and today's date. Please ask if you have any questions about our fees, our policies, and/or your responsibilities.

Insurance – When making an appointment, it is your responsibility to confirm with your insurance company that Dr. Oliver is currently under contract with **your** plan. If your plan requires that you have a referral prior to seeing a specialist, please contact your primary care physician so that you have the referral at the time of your appointment. If you do not have your referral at the time of your appointment, you will need to reschedule your appointment or choose to be seen without the insurance benefits and pay for your visit in full.

You are responsible for knowing your insurance benefit coverage. We will gladly file your insurance claim on your behalf. We allow 45 days from the date the claim is filed for the insurance company to pay. If the insurance company does **NOT** pay within this time, you will be responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria, i.e., deductibles, non-covered services, co-insurance, coordination of benefits, or pre-existing conditions. You are responsible for all co-payments and deductibles at the time of service.

Check In – Please bring your current insurance card with you to EACH visit. Without the insurance card, we will be unable to file your insurance, and you will be responsible for all charges for that visit. On follow-up visits, you will be asked to verify all demographic and insurance information so that our records remain up to date. Please be prepared to pay for the current visit as well as any past balances on your account. Payment and copayments, deductibles, or fees for non-covered services will be required at the time of service. For your convenience, we take cash, check, CareCredit, and all major credit cards.

Non-Covered Services – An insurance Waiver may be required to acknowledge understanding of your responsibility for paying for non-covered services. If you are coming in for a non-covered service, please be prepared to pay for the service in full.

Return Check Fees – Any returned check from the bank for non-payment shall result in the patient's or Guarantor's account being assessed a \$35.00 fee per check.

Pathology Fees and Lab Tests – If your visit includes biopsies or lab tests, the specimens are sent out for processing. You will receive separate billings from the laboratory performing the services. You are responsible to notify us if your insurance company requires a particular facility for coverage of the processing.

Assignment of Benefits

I hereby authorize my insurance company, including Medicare; if I am a Medicare Beneficiary, to make payments to Coastal Ear, Nose and Throat, LLC for medical or surgical services or items rendered to me or my dependent by Coastal Ear, Nose and Throat, LLC. I understand that I am financially responsible for the

322 Commercial Drive, Ste. 2 Savannah, GA 31406 | 200 Blue Moon Crossing, Ste. 103, Pooler, GA 31322

912.355.2335 | 912.450.2336

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charges. I authorize Coastal Ear, Nose and Throat, LLC to release any and all of my records to my insurer, or any other third-party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance, and health information. I understand that knowing the terms, limitations, and guidelines of my health insurance is my responsibility as a patient, and I assume all financial responsibility for any charges incurred as a result of policy termination, coordination of benefits, or limitations otherwise not mentioned that result in non-payment.

Privacy Statement

You have the right to review our privacy notice, request restrictions, and revoke consent in writing after you have reviewed our privacy notice. Signing below signifies that you have had the opportunity to view the privacy notice by requesting a copy or reading a copy located in our office, and you agree to the privacy policy of our office.

By signing below, you acknowledge that you have read, understand, and agree to the Coastal Ear, Nose, and Throat Financial Policy, Notice of Privacy Practices, and Assignment of Benefits.

Printed Name of Patient: _____ Date of Birth _____

Responsible Party Name: _____ Date of Birth _____

Responsible Party Address: _____

X _____ Date _____

Signature of Patient or Responsible Party

Please list the names of the persons to whom we may disclose the patient's private health information and state how the individual is related to the patient:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

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