



# Financial Agreement

We are committed to providing you with the best possible care. Our staff works as a team to provide medical expertise as well as old-fashioned courtesy and compassion. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept cash, check, MasterCard and Visa.

As a courtesy to our patients, we will file and accept payment directly from your insurance company. Since most insurance companies do not pay 100%, you are responsible for your portion at the time of service. Our office will estimate your financial responsibility. Please keep in mind this only an estimate based on the information provided by your insurance company.

Returned checks (return check fee of \$25 will be assessed), and balances older than 90 days will be subject to additional collection fees and interest charge of 1% per month. **Charges may also be made for broken appointments and appointments cancelled without 24 hour advance notice.**

While filing of insurance claims is a courtesy that we extend to our patients, you must realize:

1. Your insurance is a contract between you, your employer and the insurance company.
2. Insurance may pay all, some or none of your bill. Your portion is due prior to and at the time of service. If your insurance does not make payment within 30 days you will be billed for the unpaid balance.
3. Not all services are a covered benefit. Some companies arbitrarily select certain services they will not cover. Please familiarize yourself with your insurance coverage. Benefits vary.

We must emphasize that as a health care provider, our relationship is with you, not your insurance company. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, don't ignore our bills. Instead, contact us promptly for assistance in managing your account.

If you have questions about information, or if you are uncertain of your insurance coverage, please do not hesitate to ask our staff. We are here to help!

► I hereby authorize payment of medical benefits to **Cape Fear Otolaryngology** for services rendered, as well as the authority to submit claims and accept assignment of benefits on behalf \_\_\_\_\_, \_\_\_\_\_ & \_\_\_\_\_ Insurance Company (ies). I have authorized a release of information related to my claims.

\_\_\_\_\_  
Patient/Guarantor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
CFO Witness

\_\_\_\_\_  
Date