



## Financial Policy

Online Payment Processing  
Available  
[www.nkyent.com](http://www.nkyent.com)



Thank you for choosing us as one of your health care providers. We are dedicated to providing you with quality care and efficient service. Your understanding of our financial policy is essential. If you have any questions regarding any aspect of our policy, please ask us.

We accept Visa, MasterCard, Discover, American Express, Health Savings Accounts, cash or check.

### **Insurance**

Though we file insurance claims as a courtesy to our patients, all charges are ultimately the responsibility of the patient/guarantor as of the date the services are rendered. Please understand that not all services are covered by all insurance carriers. It is thus highly recommended that patients communicate with their insurance companies to understand their benefits and limitations to their benefits. When services are not covered by insurance, full responsibility remains with the patient/guarantor.

### **Referrals**

Some insurance companies may require a referral. It is the patient/guarantor's responsibility to obtain the referral prior to the time of service. When required, the patient/guarantor will be responsible for payment in full at time of service if a required referral is not provided.

### **Co-pays and Past-Balances**

All co-pays and all past-balances are due at the time of service. Self-pay patients are required to pay a \$50 deposit at the time of service and any remaining balance is due upon receipt of a statement.

### **Deductibles & Coinsurance**

If you have a deductible and/or coinsurance, you are required to pay 50% of your estimated charges at your office appointment or 24 hours prior to surgery. Any remaining balance is due upon receipt of a statement.

If your balance is not paid, it will be automatically placed with a professional collection agency and reported to the credit bureau. If this occurs, you will be responsible for collection fees, interest and attorney costs.

I have read and fully understand the financial policy set forth by Head and Neck Surgery Associates, PSC and Center for Surgical Care. I agree to the terms of this financial policy. I also understand and agree that the terms of this financial policy may be amended by the practice at any time.

Print Name	Signature	Date
If Patient is a Minor Under Age 18: Print Patient Name		Relationship to Patient of
Person Signing		