ADOBE
ENT & ALLERGY

Assignment of Benefits/ Financial Agreement
Signature on File

RELEASE OF INFORMATION: Adobe ENT & Allergy may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Adobe ENT & Allergy for reimbursement for services rendered, and (2) any health care provider for continued patient care. Adobe ENT & Allergy may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

COVERAGE: An attempt will be made to obtain and comply with insurance company requirements. However, it is ultimately your responsibility as a patient to verify your plan benefits, and whether or not Adobe ENT & Allergy, is a contracted provider, prior to having any services rendered. Any and all face to face encounters with Adobe ENT & Allergy provider qualifies as an office visit and will result in a claim submission to your insurance carrier. Co-payment, co-insurance and deductible amounts will apply and are the responsibility of the patient.

OTHER INSURANCE: I understand that Adobe ENT & Allergy maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Adobe ENT & Allergy has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Adobe ENT & Allergy if I belong to a plan that does not appear on the above mentioned list.

VALID INSURANCE: Insurance companies require the submission of all claims within a specified time limit. If you have changes in your insurance coverage, and you fail to inform us of the change within twenty-one days of your visit, you may be responsible for the charges. Denials often arrive after the filing limit has expired, thus preventing us from being able to re-file a new claim with your new carrier. To ensure that you are not responsible for the charges, please make sure that we always have up to date information regarding your insurance coverage. Again, any denied claims for lack of correct insurance information will be applied to patient responsibility.

REFERRALS: If your plan requires a referral from your primary care physician, it is your responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If your plan requires a referral and you do not obtain one, you will be held responsible for the visit charges in full at the time of service.

DISPUTES: Co-payment, co-insurance and deductible amounts must be paid at the time of service. Any account balances will also be collected at the time of your visit. Any unpaid or disputed balances must be resolved within 90 days from the date of service. Adobe ENT & Allergy reserves the right to turn accounts over to a third party collection agency after 90 days. The responsible party or guarantor of this account will be responsible for all collection fees, legal fees, and any other fees associated with the account.

NO SHOW/LATE CANCELLATION OF APPOINTMENTS: Effective Oct 1, 2019 there will be a $25.00 no show fee charged to your account for no shows and or canceled appointments with less than 24 hours notice. There will be $150.00 no show fee charged to your account for no shows and or canceled appointments with less than 72 hours notice related to surgeries, allergy tests, hearing tests and sleep studies. You may also be discharged from the practice after 3 cumulative no shows.

DISMISSAL FROM PRACTICE: Adobe ENT & Allergy reserves the right to dismiss patients who are not compliant with any one of the following:

- Refusal to comply with recommendations from the provider.
- Does not comply with office policies.
- Refuses to cooperate with staff.
- Repeatedly disputes fees that are fair and are consistent with the services provided.
- Displays threatening, hostile attitude or behavior to physicians or staff
- Continues to abuse prescription drugs or controlled substances after physician intervention.
- Refuses to pay outstanding balances.
- 3 no-shows or other non-compliance issues that interfere or jeopardize patient treatment or safety.
- Breakdown of communication with patient and/or family resulting in a lack of trust that makes it medically impossible to treat the patient.

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NON-COVERED SERVICES: I understand that Adobe ENT & Allergy's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Adobe ENT & Allergy to obtain necessary health care service plan authorizations.

FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Adobe ENT & Allergy, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Adobe ENT & Allergy for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Adobe ENT & Allergy . If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Adobe ENT & Allergy. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

You will be responsible for payment of all services if any of the following circumstances apply:

- **If you do not have insurance or failed to notify us that your insurance has terminated or changed;**
- **If you do not have a referral and/or authorization when required and have elected to be seen;**
- **If you are with an insurance company we are not contracted with; or**
- **If a claim denial from the insurance company, for any reason, is not to be resolved.**

I have read and understand this notice.

_____ _____

Name of Patient Patient Signature

_____

Date