ENT FACULTY PRACTICE, LLP

OFFICE POLICY

PATIENT FINANCIAL RESPONSIBILITY

I agree to assume all financial responsibility for the medical care, treatment and other related services provided to myself and/ or to ____ by ENT Faculty Practice, LLP. (Name of Patient)

If my co-payment is not paid at the time of my visit I am responsible for an administrative charge of $20.00 in addition to my co-pay.

If payment is not made today, I understand that any balance owed must be paid full within 30 days from the date of my bill; If payment is made later than 30 days from the date of my bill, I understand that I am responsible for interest charges, which will accrue at a rate of 1.5% per month.

I am responsible for the collection fees, attorney's fees and any other costs associated with collecting this bill or any of my bills in the future. If I fail to remit any fees due to ENT Faculty Practice, LLP. If a check I issue to ENT Faculty Practice, LLP is returned unpaid by my bank for any reason, I agree to be responsible for a returned check charge of $25.00.

I am aware that ENT Faculty Practice, LLP cannot accept the responsibility of collecting insurance benefit. I am directly responsible to ENT Faculty Practice, LLP for payment of all balances due regardless of insurance coverage, ENT Faculty Practice, LLP agrees to complete routine medical insurance claims forms at no additional charge.

_______________________________ Signature of Responsible Party

_______________________________ Print Name of Responsible Party

_______________________________ Print Patients Name

_______________________________ Date