SOUTHWESTERN COLORADO EAR, NOSE, AND THROAT ASSOCIATES
Gregory M. Schackel, MD, Board Certified in Otolaryngology
Mercy Medical Plaza • One Mercado Street, Suite 205 • Durango, CO 81301
phone 970-385-7272 • fax 970-385-7299 • www.swcoent.com

Financial Responsibility Agreement

(Please read, and sign full name at the bottom)

This is a legally binding agreement between Southwestern Colorado Ear, Nose and Throat Associates, and you, as the patient. It describes your financial obligations. You must read this, sign it and return it to us prior to your first treatment. The term "SCENT" means Southwestern Colorado Ear, Nose and Throat Associates. The terms "I", "me", "my", "you", or "your" refer to the patient.

SCENT is committed to give you the best care. In return, I agree to be financially responsible for payment of SCENT's services. Acceptable forms of payment are cash, check or credit card.

As a courtesy, SCENT will file your insurance claim. Insurance cards are copied regardless of the type of visit. I agree to be responsible for payment of SCENT's services, regardless of whether the services are covered by my insurance and regardless of the extent of payment, if any, by my insurance. I agree to pay any balance remaining on my account for any reason after my insurance has been processed.

I agree to give SCENT complete and accurate insurance information for primary and secondary insurance coverage including referral forms from other providers (if applicable) and all identification and benefit cards/ documents required for claim accuracy. I understand that failure to supply complete and accurate information may result in denial of my claim or delay payment. I agree to pay any balance remaining on my account for any reason after my insurance has been processed.

Referrals are my responsibility. I agree that if my health plan requires me to furnish a referral and the referral is not in place prior to my appointment, I agree to pay in advance a non-binding estimate of SCENT's charges or reschedule my appointment.

All services provided in SCENT's office are deemed medically necessary by the physician. I understand that failure to have the procedure performed is against medical advice and may void my insurance coverage. I agree to pay any balance remaining on my account for any reason after my insurance has been processed.

I understand that my insurance may or may not agree with the UCR (usual, customary and reasonable) charges for the local area and my benefit plan may not cover all services or may even deny payment for services that have been authorized in advance. I agree to pay any balance remaining on my account for any reason after my insurance has been processed.

If SCENT attempts to pre-certify any procedure and my insurance company indicates that the procedure is not a covered benefit, I agree to pay a non-binding estimate of SCENT's charges prior to scheduling the procedure.

(over)

If I do not have insurance or have not met my deductible or if I have a high deductible policy, I agree to pay a non-binding estimate of SCENT's charges for services in advance.

I understand that if SCENT has a contract with my insurance, SCENT will receive payment from my insurance company for covered services to the extent provided by my insurance. I agree to pay co-payments at the time of service. I agree to pay deductibles and co-insurance amounts upon receipt of a statement.

I understand that any invoice or receipt issued by SCENT at the time of service is a non-binding estimate only and additional charges may apply depending upon the services rendered. I agree to pay any balance remaining on my account for any reason upon receipt of a statement.

DIRECT PAYMENT AUTHORIZATION

I HEREBY AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS AND/OR SURGICAL BENEFITS, INCLUDING ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO SOUTHWESTERN COLORADO EAR, NOSE AND THROAT ASSOCIATES. THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A COPY OF THE AUTHORIZATION IS AS VALID AS THE ORIGINAL.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, SURCHARGES, LATE FEES, INTEREST OF 18%, ATTORNEY FEES, $25 NO SHOW FEES AND COLLECTION CHARGES, WHETHER OR NOT THEY ARE PAID BY MY INSURANCE.
(The no show fee is charged when an appointment is not cancelled by 4 pm the working day before the appointment is scheduled.)

I hereby authorize Southwestern Colorado Ear, Nose and Throat Associates to release all medical information necessary to obtain payment.

_____
Patient Signature

Print Name:_____

Date:_____