Carolina Ear & Hearing Clinic Financial Policy *(eff. 9/30/2020)*

Thank you for choosing CEHC as your health care provider. Our providers are committed to providing you with the best medical care available at a cost that is both fair and reasonable. Please read this Financial Policy carefully and indicate your understanding and agreement with your signature and the date.

1. **CURRENT INSURANCE CARD** – Patients cannot be seen if we do not have a CURRENT insurance card. You will be asked for your CURRENT insurance card at each visit. If a CURRENT insurance card cannot be provided, you will have the opportunity to pay for the visit or reschedule. If your insurance changes and we are not notified, you will be responsible for all charges.
2. **CO-PAYS, DEDUCTIBLES, CO-INSURANCE** – All co-pays, deductibles and co-insurance amounts are collected at the time of service. This includes any amount due for surgery or in-office procedures. Our contract with your insurance requires us to collect these fees; we are unable to waive or write-off any co-pay, deductible or co-insurance.
3. **OUT OF POCKET EXPENSES** – Insurance companies do not cover miscellaneous supplies or administrative work, nor do we contract with insurance companies for coverage of hearing aids and related services/supplies.
    a. **SUPPLIES** – Any supplies you receive from our office must be paid in full at the time of service.
    b. **HEARING AIDS** – We will not bill insurance for services related to a hearing aid consultation or purchase. We will provide you with a copy of the encounter detailing your visit to submit for reimbursement.
    c. **TESTING** – Specialized testing performed by our audiologists may not be covered by your insurance. This includes some balance and vestibular testing that may be recommended by your doctor. For example, an SOT will require a payment of $100 at the time of service.
    d. **OUTSIDE FORMS** – Disability forms, CMLA forms, leave of absence forms and/or any requested correspondence that is not associated with reimbursement of a claim will be charged to you prior to completion of the form and will be based on time and volume.
    e. **MEDICAL RECORDS** – We will be happy to furnish you with a copy of your medical records. You will need to request the records in writing and a charge will be assessed based on time and volume. There is a two-week turnaround for all medical records requests.
4. **REFUNDS**- Are normally issued to our patients via check. If you require a credit card refund, it must be applied to the same card used to make the original purchase, and it will be subject to a processing fee.
5. **PLEASE REMEMBER** – **Your insurance is a contract between you and your insurance company.** CEHC contracts with most major insurance plans; however, it is your responsibility to understand your coverage and benefits and to determine if our providers are in-network with your insurance.
    a. **BILLING INSURANCE** – As a courtesy to you, we will file charges with your PRIMARY insurance company. We do not file charges with secondary or tertiary insurance; however, some claims may bill automatically if we have accurate secondary information. Charges not paid by your insurance company after 90 days will be billed directly to you.
    b. **AUTHORIZATION** – If your insurance requires an authorization for an appointment with a specialist, it is your responsibility to obtain that authorization prior to your appointment. If you do not have an authorization, you will be responsible for charges at the time of service.
    c. **THIRD PARTY INSURANCE** – We will not bill third party insurance. If your visits are being covered by Workman's Comp or disability insurance, you will be responsible for all charges at the time of service. We will provide you with a copy of the encounter detailing your visit to submit for reimbursement.
    d. **NON-COVERED SERVICES** – In the event your insurance determines a service to be "not covered," you will be responsible for payment.
6. **NO-SHOW FEES** – We require a 48-hour notice for proper cancellation or rescheduling of an appointment or in office procedure, failure to provide notice will result in a $50 charge. For surgery, we require a 7 business day notice of cancellation, failure to provide notice of surgery cancellation will result in a $250 charge.
7. **SELF-PAY** – If you do have health insurance, or we are not contracted with your insurance plan, you will be considered a self-pay patient and will be required to pay all charges, in full, at the time of service.
8. **DIVORCED/SEPARATED PARENTS of a minor patient** – The responsibility for payment of services rendered to dependent children whose parents are divorces/separated rests with the parent who brings the minor to the office visit. Any court ordered responsibility judgment must be determined between the individuals involved and cannot be considered by this office.

Financial Agreement / Patient Acknowledgment of Financial Responsibility

We require every patient to read the preceding Financial Policy and sign the following Financial Agreement prior to seeing one of our medical professionals. Your clear understanding of this Financial Policy is essential. Please ask to speak with any member of our billing/insurance team if you have questions.

FINANCIAL RESPONSIBILITY: Patient Name _____

I hereby guarantee payment of charges for the above named patient.

Print Name:

Signature:

Relationship to Patient:

Date:

ASSIGNMENT OF INSURANCE BENEFITS: I authorize the release of any medical information necessary to process the insurance claim for services rendered by Carolina Ear & Hearing Clinic and its providers. I also authorize payment of benefits directly to Carolina Ear & Hearing Clinic. I understand that I am financially responsible for charges not covered by this authorization.

Signature of Policy Holder

or Representative:

Date:

MEDICARE ASSIGNMENT (if applicable): I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the Carolina Ear & Hearing Clinic and the medical professional furnishing the service.

Signature of Policy Holder

or Representative:

Date: