Bluegrass Ear, Nose & Throat Clinic, PSC

General Otolaryngology • Allergy & Sinus Disease • Audiology & Hearing Aids

Clark Clinic B • 225 Hospital Drive, Suite #265 • Winchester • Kentucky • 40391

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OFFICE POLICIES AND PROCEDURES

Thank you for choosing **Bluegrass Ear, Nose & Throat Clinic, PSC**, for your ear, nose, throat and allergy problems. We want to provide the best possible service to our patients. To make your visit as pleasant as possible, the following office policies will be helpful to become familiar with.

- Please bring copies of any films (CAT scan, MRI, etc.), results of diagnostic tests relating to your current problem, any records from other treating physicians you have seen for this problem or from the physician who referred you to us.
- Please bring all medications or a list of all your medications that you are taking to **every** visit.
- Please bring your most current insurance card(s) to **every** office visit.
- Please inform us of any address change and/or change of medical insurance.
- We request that all new patients arrive 15 minutes early for their scheduled appointment.
- We kindly ask that you provide a 24-hour notice for appointment cancellations. Failure to provide this notification would be considered a no-show and a surcharge may be applied to your account for the missed appointment. If you have three (3) no-shows in a six-month period, you will be asked to find another provider.
- If you are more than 15 minutes late for an appointment, you will be asked to reschedule unless the schedule permits you to be worked in at a later time (we will make every effort to accommodate you if the schedule permits).
- Patients will be seen in the following order: (1) Emergencies; (2) Scheduled appointments (3) Work-in patients (acute illnesses).
- If you have **Medicare** only, you will be required to pay your 20% coinsurance at the time of service.

CONSENT FOR SERVICES

1. **Consent to Wireless Telephone Calls**: If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify Bluegrass Ear, Nose & Throat Clinic, PSC, to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the office affiliates, contractors, servicers, attorneys or its agents including collection agencies.
2. **Consent to Email Usage**: If at any time I provide an email address at which I may be contacted, unless I notify Bluegrass Ear, Nose & Throat Clinic, PSC, to the contrary in writing, I consent to receiving statements, bills, marketing material for new services and payment receipts at that email address from Bluegrass Ear, Nose & Throat Clinic, PSC.

FINANCIAL POLICY AND RESPONSIBILITY

We are committed to providing you the best possible care. In order to better serve you by keeping our overhead costs low, we have adopted the following financial policy. Please read and familiarize yourself with this policy so that future misunderstandings regarding our billing and payment policy can be avoided.

1. We participate with most major insurance plans. If you are unsure whether your insurance is one with which we participate, please refer to the provider list supplied by your insurer or call

their member services. Please remember that you are responsible for any bill or portion of a bill that is not paid by your insurance company. Please note that if we do not participate with your insurance, we do not accept any fee schedule reductions and you are responsible for the full amount not paid by the insurance plan.

2. We are obligated by contract to collect co-payments (co-pays) at the time of service, so please bring your co-pay with you. If you are not sure you have a co-pay or do not know the amount, please contact your insurance company at the customer service hotline number listed on your insurance ID card.
3. Because of the many insurance plans on the market today, it is nearly impossible for us to stay well informed about each individual policy. It is ***your responsibility*** to know what your insurance will and will not cover and to ensure that your insurance company abides by the plan you have. We will file appeals and follow up your claim as much as we can. However, if you are experiencing delays or difficulties with your insurer and the payment of benefits, you should contact the ***Consumer Protection and Education Division of the Kentucky Department of Insurance at 1-800-595-6053***.
4. If you have no insurance, we require payment of $300 prior to your seeing the doctor and any additional charges will be collected when your appointment is completed. The additional charges are for diagnostic tests and procedures that may need to be performed.
5. If your insurance company has not paid your claim after 90 days, the full amount of the bill is your responsibility and payment is due immediately. Furthermore, if for any reason, the account is turned over to a collection agency, the patient will be responsible for the collection fee of 30% and should non-payment of your account result in litigation, the collection fee shall increase to 50%, and the patient will also be responsible for court costs and service of summons cost. In addition, failure to remit payment on a past due account will result in termination of the physician/patient relationship.
6. A service charge of $30.00 will be assessed for each returned check. Checks returned for non-sufficient funds must be paid in full within 10 days or will be turned over to Clark County Attorney's Office and subject to applicable fees.
7. A surcharge of $25.00 may be applied for missed appointments (i.e. not showing up for an appointment without calling to reschedule or cancel).
8. **Please Remember: Your insurance is a contract between you, your employer, and your insurance company. You are personally responsible for any bill, or portion thereof, not paid by your insurance company.**

I have read the above and understand the office policies and procedures, my consent for services, my financial responsibilities in exchange for the medical care provided by Bluegrass Ear, Nose & Throat Clinic, PSC.

✗____ ______/______/20_____

Signature: ❒ Self ❒ Mother ❒ Father ❒ Legal Guardian **Date Signed**

✗____

Name of Patient or LEGAL Guardian/Responsible Party (PRINT PLEASE)

If you have any questions please do not hesitate to address them to our practice manager/coordinator who would be delighted to answer or clarify any questions you may have.

Thank you kindly and welcome to,
Bluegrass Ear, Nose & Throat Clinic, PSC