Pinnacle ENT ASSOCIATES LLC
CHESTER COUNTY OTOLARYNGOLOGY & ALLERGY ASSOCIATES DIVISION

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Financial Policy

Patient: _____ DOB: _____

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to contact our billing office at (610) 902.6092.

We ask that all patients read and sign our Financial Policy and HIPAA form as well as complete our Patient Intake form. Medicare patients may also be required to sign an ABN (Advanced Beneficiary Notice), should we believe that Medicare won't cover your services.

In order to accurately diagnose and treat your medical symptoms, your physician may recommend a procedure that is not included in the fee for your office visit. We will submit all claims to the insurance company on your behalf; however, you will be billed for any non-covered services, deductibles, co-pays and/or co-insurance. Some of these services include:

- Audiology (hearing) testing
- Earwax removal (impacted)
- Laryngoscopy (examination of the back of the throat and vocal cords)
- Nasal endoscopy (examination of the nasal passages and sinus openings)
- Biopsy or excision of lesion
- Foreign body removal
- Incision and drainage of abscess
- Fine needle aspiration (biopsy with a needle)
- Nasal cautery or packing (to control nasal bleeding)
- Myringotomy (incision of eardrum)

For your convenience we accept Visa, Mastercard, Cash, Check or Money Order. There will be a charge of $20.00 for returned checks.

It is the responsibility of the patient to ensure any referrals, precertification or authorizations have been obtained prior to your appointment. In the event your plan procedures are not followed prior to your appointment, your appointment may be rescheduled.

Delinquent accounts will be turned over to a collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days. In the event your account is turned over for collection, you will be responsible for all reasonable collection costs at the time the account is considered delinquent.

Thank you for choosing us as your health care provider. We appreciate the opportunity to serve you.

_____ _____

Patient Name (Printed) DOB

_____ _____

Patient Signature (or Responsible Party) Date

Assignment of Benefits

I hereby guarantee payment of all charges incurred at the offices of Pinnacle ENT Associates, LLC. I hereby assign and direct to pay any and all benefits of medical services under this claim directly to Pinnacle ENT Alliance, LLC. I hereby authorize the release of any medical information requested by the insurance companies.

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Patient's Signature Date