Financial Policy

Thank you for choosing us as one of your health care providers. We are dedicated to providing you with quality care and efficient service. The service you have elected to participate in implies a financial responsibilityon your part. This responsibility obligates you to ensure payment in full of your fees. Your understanding of our financial policy is essential. If you have any questions regarding any aspect of our policy, please ask us.

We accept Visa, MasterCard, Discover, American Express, Health Savings Accounts, Care Credit, cash or check. You may make a payment anytime online at **www.nkyent.com** and through MyChart.

Insurance
Though we file insurance claims as a courtesy to our patients, all charges are ultimately the responsibility ofthe patient/guarantor as of the date the services are rendered. Please understand that not all services are covered by all insurance carriers. It is thus highly recommended that patients communicate with their insurancecompanies to understand their benefits and limitations to their benefits. When services are not covered by insurance, or if services are being provided on a self-pay basis, full responsibility remains with the patient/guarantor.

Referrals
Some insurance companies may require a referral. It is the patient/guarantor's responsibility to obtain the referral prior to the time of service. When required, the patient/guarantor will be responsible for payment in full at time ofservice if a required referral is not provided.

Co-pays and Past-Balances
All co-pays and all past-balances are due at the time of service. If your balance is not paid, it will be automatically placed with a professional collection agency and reported tothe credit bureau. If this occurs, you will be responsible for collection fees, interest and attorney costs.

SELF PAY
New self-pay patients are required to paya $150.00 payment at the time of service and any Established self pay patients are required to pay $50.00 at the time of service. These required payments are not payments in full. Any remaining balance is due upon receipt of statement.

Deductibles & Coinsurance
If you have a deductible and/or coinsurance, you are required to pay 50% of your estimated out of pocket expenses at your office appointment or 24 hours prior to surgery. Any remaining balance is due upon receipt of a statement.

Your bill from your visit includes being evaluated by one of our providers. Additional cost may be incurred from other testing or treatments performed during your visit. These costs may include:

- hearing tests (audiogram)
- scope of nose or throat (endoscopy)
- evaluation by hearing specialist (audiologist)
- ear cleaning (cerumen removal, ear microscope)
- minor procedures (biopsies, ear tube placement)

These additional services may show up as additional costs on your bill. Your insurance could apply these services to your deductible, copay or co-insurance. You could be responsible for these additional costs. If you have any questions about benefits, please contact your insurance company directly.

These tests are recommended by your provider to help determine the cause of your symptoms and guide treatment decisions. You are welcome to refuse any additional services but doing so may limit the providers ability to best diagnose and treat your symptoms.

Contact
Important note: By providing a cell phone number as your contact number, you consent to receiving automatedor prerecorded appointment reminder calls, important calls, and/or text messages on your cell phone. Your cellphone carrier's standard rates may apply for calls or text messages to your cell phone. If you would like us to utilize a different number—please provide that number instead of your cell phone number. You may revoke your consent at any time by calling 859-781-4900.

I have read and fully understand the financial policy set forth by ENT & Allergy Specialists and Center for Surgical Care. I agree to the terms of this financial policy. I authorize my insurer to pay any benefits directly to ENT & Allergy Specialists and Center for Surgical Care. I agree to pay ENT & Allergy Specialist and Center for Surgical Care the full and entire amount of all bills incurred by me or the patient named below including if applicable, anyamount due after payment has been made by my insurance carrier. I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately financially responsible to ENT & Allergy Specialists and Center for Surgical Care for any services rendered. I also understand and agree that the terms of this financial policy may be amended by the practice at any time.

Print Name	Signature	Date

If Patient is a Minor Under Age 18:	Print Patient Name	Relationship to Patient of Person Signing