REFERRAL AND PAYMENT RESPONSIBILITY

I, the guarantor, understand that I am fully responsible for all fees payable to Ear Nose & Throat Associates of Johnstown, Inc. for any medical care rendered by the physicians or staff members to me or the patient for whom I am financially responsible.

REFERRALS:

If my insurance company requires a referral, I understand that it is my responsibility to obtain a referral before my scheduled appointment and to bring that referral with me to the appointment. **If I do not have a valid referral at the time of my appointment, I acknowledge that I am personally responsible for any services that are not covered by my insurance.**

LEGAL, MOTOR VEHICLE, OR WORKERS' COMPENSATION CASES:

I understand that if I am involved in any of these cases, I must present all relevant documentation before my appointment. I must also present my personal health insurance card, in the event that services are denied under my case. If all the appropriate information is not presented prior to my appointment, I understand and agree the all unpaid balances become my responsibility.

CLAIM SUBMISSION:

Depending on my insurance plan, the physician's office may file a claim for services directly to the insurance company. I am aware that the physician I am to see participates or does not participate with my health insurance plan(s). **I agree to contact the customer service department of my insurance company if I am unsure of their requirements or my benefits.**

NON-COVERED SERVICES:

I understand that this office may provide me with special services that may not be covered by my insurance company. In the event that I may require any of these special services, I am aware that I am fully responsible for payment.

CO-PAYS, DEDUCTIBLES, AND CO-INSURANCE:

I understand that it is my responsibility to know the requirements of my health insurance plan(s). By signing this agreement, I acknowledge that I am fully aware of my co-pays, deductibles and co-insurance. I acknowledge that the physicians' office will bill me for balances due and that I am fully responsible for all balances billed to me. **I am also aware that my co-pay must be paid the day of my visit.**

PAYMENTS PLANS AND COLLECTIONS:

In the event that I do not have insurance, I understand and agree that payment is required the day of my visit. If I am unable to pay my entire balance, I may arrange to make reasonable monthly payments. If I am not consistent with my monthly payments, after attempting one notice, the credit bureau may be notified and any unpaid balance may be placed with a collection agency. ***I understand and acknowledge that the physicians' office can submit my unpaid balance due over 121 days old to a collection agency and notify the credit bureau.***

I have read and fully understand all of the above statements. I agree to comply with all stated requirements.

_____ _____

Patient/Guarantor's Signature Date

_____

Staff Witness