FINANCIAL POLICY

Payment is due at the time of services. We accept cash, check, VISA, Mastercard, American Express and Discover. We also offer a credit line through Care Credit which has flexible payment plans and low interest rates. If you any questions, please let us know before being seen by the doctor.

REFERRALS If you have an HMO or similar plan, you will need a referral from your primary care physician to see a specialist. If we have not received this referral prior to your arrival at our office, your appointment will be rescheduled. It is your responsibility to know if a referral is required and to obtain one. If one is not obtained, you will be responsible for the entire bill.

INSURANCE BENEFITS Please be aware that when a patient requires a visit to a specialist, there are diagnostic procedures required to diagnosis and evaluate for treatment that cannot be done by a family physician. These procedures may be done during the normal course of the exam by the specialist. Your insurance company and our billing may call these slightly different names, but they are determined by the procedure codes. The possible procedures you may expect based on your presenting complaints and/or findings during the exam are listed below, but are not limited to:

30901 Nasal Hemorrhage Control
31237 Nasal Endoscopy with debridement
31575 Larynoscopy
69210 Cerumen Removal (ear Wax)
92504 Binocular Microscopy (Microscope guidance)
92511 Nasopharyngoscopy with endoscope
92541 Spontaneous Nystagmus Test
92542 Positional Nystagmus Test
92567 Tympanometry
30300 Foreign Body Removal (not ear)
69200 Foreign Body Removal (ear)

Depending on your insurance policy provisions, these procedures and others may fall under a separate benefit other than your office copay, such as a deductible or coinsurance. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim; therefore, any quote for services will be considered an estimate only and any payment will be considered a partial-payment only until such time that the insurance company processes your claims. Your insurance is a contract between you and your insurance carrier; payment for services is ultimately your responsibility. It is extremely important for you to know your coverage.

FORMS FEE Any forms which you require to be filled out by the physician must be presented in a timely manner so to allow time to complete them. There will be a $25.00 fee which must be paid prior to the forms being completed. This is in respect to the specialist as it takes approximately 30 minutes or more to complete most forms, such as FMLA. There is no exception to this rule.

NO SHOW FEE We are committed to making you an appointment at your earliest convenience; likewise, we request a courtesy call at least 24 hours in advance if you are unable to keep your appointment to allow for other patients to be seen. Due to the alarming number of appointments not being kept or cancelled in a timely manner, all "no shows" will be charged a fee of $50.00. Multiple missed appointments may result in our request for you to find another specialist.

MEDICAL or BILLING RECORDS FEE Any request for medical or billing records must be accompanied by a signed request and authorization for release of information (this form is available at the front desk). We will make every effort to provide these copies within 10 business days, so please make your request well in advance of other physician appointments, etc. Depending on the recipient of the records, a fee of $25.00 may be assessed.

RETURNED CHECK FEE There is a $25.00 fee for checks returned for any reason. If the returned item is not paid immediately, we will report it to the Justice of the Peace for our precinct. Court and misc. fees charged by the JOP are in excess of $300.00.

COLLECTION AGENCY Please be aware that Lone Star Ear, Nose and Throat Care utilizes a collection agency for unpaid bills. If your account is transferred to collections, any and all fees assessed by the agency will be added to the balance on your account, to include, but not limited: to a placement fee of $18.55, an additional percentage of your balance (up to 50%) and lawyer fees. Any patient sent to collections will be dismissed from the practice until the balance is paid in full.

SURGERY DEPOSIT If surgery is recommended, you will be required to pay a $50.00 deposit in order to schedule the surgery. The deposit will be applied to your coinsurance balance, which will be due no later than three days prior to the date of the surgery. If you cancel your surgery for any reason, the deposit will not be refunded.

WORKERS COMP We do not accept Worker's Compensation.

This practice's policies on billing and charity care are available for review.

ASSIGNMENT OF BENEFITS I request that payment of insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Lone Star Ear, Nose and Throat Care or Mark A. Bickert, DO for any services provided to me. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable by my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by Lone Star ENT Care.

FINANCIAL RESPONSIBILITY STATEMENT I have read this notice of possible procedures necessary to verify or obtain a diagnosis and evaluate for treatment. I am aware that these specialized procedures and equipment are available only through a specialist and that the fees will be billed to my insurance, if any. I understand there are many other procedures which may be performed as part of my diagnosis or treatment which are not listed above. I will be responsible for any amount not covered by an insurance policy. If I do not have insurance, I am aware that I will be responsible for the bill. It is my responsibility to notify Lone Star ENT Care of any changes in my insurance coverage. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of privacy rights.

Signature _____

Printed name _____

Relationship to patient, if different _____

Date _____