SCENT
ALLERGY & SLEEP MEDICINE

Patient Financial Responsibility Policy and Consent for Treatment

Thank you for choosing South Carolina ENT, Allergy & Sleep Medicine (SCENT) to serve the healthcare needs for you and your family. We are pleased to participate in your healthcare and look forward to establishing a lasting relationship as your healthcare provider. As part of this relationship, we have outlined our expectations for your financial responsibility in our Patient Financial Responsibility Policy. Please read this document thoroughly.

Address Change
It is important that we have your correct address information on file. Please advise us anytime there is any change to your address, telephone or other contact information.

Co-payments
Co-payments are collected at the time of check-in. We accept cash, checks, most major credit cards and Care Credit. We are contractually required, by your insurance company, to collect a co-payment at the time of service.

Billing
If you have an additional balance after your visit you can expect to receive a billing statement. Statements are mailed out on a monthly basis. Payment is expected within ten days of receipt of your statement.

Failure to Pay
Patients who ignore collection notices and fail to pay their balance will be sent to an outside collection agency. Patients sent to an outside collection agency risk negative credit ratings and possible dismissal from the practice.

Should your account balance become uncollectible or if you file bankruptcy, we will continue to see you on an emergency basis only for 30 days, giving you time to find a new source of medical care.

Fees
Returned checks are subject to a $25.00 fee.

If you must cancel an appointment, SCENT requires a minimum of 24 hours' notice. Failure to give 24 hours cancellation notice or failure to keep your scheduled appointment may result in a charge of $75.00. Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. We reserve the right to charge a fee for cancelled or missed appointments. This policy includes, but is no limited to, appointments for allergy testing and sleep studies.

There is an administrative fee for medical records and completing forms such as FMLA, leave of absence, disability, etc. Most records/forms requests require five to seven business days to research and complete.

Fee Schedule

FMLA and Disability Forms:	1 page = $5.00 2 pages = $10.00 3 pages = $15.00 4-5 pages = $25.00 Any additional pages over 5 are $5.00 per page.
Medical Records:	$25.00 There is no charge for medical records being sent to another healthcare provider or healthcare facility.
Letter of Medical Necessity:	$30.00

Guarantor
Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. If another party is responsible for payment of your account, you must pay your balance in full and negotiate repayment with them outside of our office. This policy includes individuals negotiating divorce agreements and/or involved in personal injury litigation.

Insurance
It is important for you to be an informed consumer who understands the specifications of your insurance policy (e.g., office visit coverage, referral/authorization requirements for specialty care, etc.). Your health insurance policy is a contract between you and your health insurance company or employer. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the needs for referrals, pre-certifications, pre-authorizations and limits on outpatient charges regardless of whether or not our physicians participate.

You must present a current insurance card at each visit. As a courtesy to you, we will bill your insurance company directly for medical services rendered. Please be advised you are ultimately financially responsible for payment of medical services rendered.

If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details of your benefits, out-of-pocket fees and coverage limits.

SCENT contracts with many insurance plans. Before your appointment, please be sure your physician is in-network and the services are covered under your plan. If your physician is out-of-network, you will be billed for the cost of care.
If we contact your insurance carrier regarding benefits or authorization on your behalf, we are not responsible for inaccurate information provided to us by your carrier. We rely, in good faith, on the carrier to provide accurate information that may be relayed to you.

Consent for Treatment Involving Nasal Endoscopy and/or Laryngoscopy
Please be aware that certain procedures performed in our office are not included in the standard office visit. These procedures will be billed separately and in addition to office visit charges. We have become aware that some insurance carriers classify these procedures as “surgery” and apply the charges to a higher deductible amount. The result may be an insurance payment for an office visit, but not a procedure. In such cases, payment for the procedure will be due from the patient. Be assured that we are following accepted billing and coding guidelines and that all procedures are performed in the best interest of patient care. Examples of in-office procedures include, but are not limited to:

- Flexible laryngoscopy: This procedure involves passing a long thin flexible scope through the nasal cavity and into the throat. The fiber optic scope enables the physician to visualize areas of the throat not readily seen using the laryngeal mirrors.
- Nasal endoscopy: This procedure uses the flexible or rigid scope attached to a light source to view areas of the nasal cavities that cannot be viewed by the physician using the standard nasal speculum and head mirror.
- Nasal endoscopy with debridement or control of epistaxis: This is the same procedure as above with removal of crusting or control of nose bleeds.

Reasonably foreseeable risks to the procedures specified above include, but are not limited to, discomfort/pain, bleeding, gagging and sore throat. In extremely rare circumstances, one may develop a reaction to the pre-procedure numbing medication (Afrin to shrink tissue and Lidocaine to numb) that could cause life-threatening problems, such as swelling of the voice box (larynx) that could make breathing difficult and require emergency airway management.

Please speak with our nurse or clinical assistants should you have any questions.

Medicare Patients
Medicare may not cover some of the services that your physician recommends (i.e., skin lesions). You will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help you determine whether you want to receive the service, knowing you may be responsible for payment. You must read the ABN carefully.

Minors and Dependents
Parents and guardians are responsible for payments for dependents at the time services are rendered. Minors and dependents must present a valid insurance card at each visit if a claim is to be filed. The accompanying parent/guardian/adult is responsible for full payment at the time of service. In the case of divorce, please do not place our office in the middle of marital disputes. It is your responsibility to work out the payment of your child's medical care between the custodial and non-custodial parent. Please note, execution of this document constitutes your agreement to financial responsibility for the patient named below.

Non-emergency Appointments
Outstanding balances or failure to pay co-payments upon check-in may result in routine or screening appointments being rescheduled.

Prompt Payment
Just as we make every effort to accommodate patients in need of medical care, we expect patients to make every effort to pay account balances promptly. Payment is due at the time services are provided or upon receipt of a statement from our billing office.

Referrals and Authorizations
Please be aware of and provide any required referrals or authorizations in advance of the appointment. If you do not provide these before care is provided you will be responsible for the cost of the care. When in doubt contact your insurance plan directly for clarification.

Self-pay Patients
Self-pay patients should be prepared to pay at the time of each visit. New self-pay patients are required to make a $200.00 payment at the time of service for initial appointments. Established self-pay patients are required to make a $90.00 payment at the time of service for any subsequent appointments. It is important to note that these payments may or may not cover the entire charge for the date of service. Any remaining balance, after the point of service fee has been applied, will be billed to the patient.

Workers' Compensation
The patient must provide, at the time of service the following items: Claim number, Name of the carrier, Date of injury, Employer at the time of injury, Name and phone number of the claim adjuster. Without this information, the patient will be held responsible for all charges and will be required to make a $200 payment at the time of service if they do not have another valid insurance policy in place.

I have read the above policy regarding my financial responsibility to SCENT for providing healthcare services. I have also read the above policy regarding consent for treatment and acknowledge that my signature below authorizes treatment for the patient named below as recommended by my provider. I acknowledge I am legally authorized to consent to treatment for the patient named below. I also acknowledge my consent for treatment will remain in effect until revoked in writing. I certify that the information provided to SCENT is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to SCENT. I agree to pay SCENT the full and entire amount of all bills incurred by me or the above-named patient, if applicable, any amount due after claims have been processed by my insurance carrier.

_____ _____
Signature of Patient/Parent/Guardian/Guarantor Date

_____ _____
Printed Name Relationship to Patient

_____
Patient Name