Sinus Solutions AT IMMUNO*e*

Office and Financial Policies

Patient Name_____ Date of Birth_____ Date: _____

In order to properly bill your insurance company, we must have complete and accurate information of both primary, secondary, and tertiary insurances. Failure to provide this may result in patient responsibility for payment. Please ensure we are in network with your insurance plan. To have understanding of our financial policies, please review the below information and sign/initial where indicated.

NO SHOW POLICY: A 24-hour advanced notice for cancellation is requested. We understand that emergencies arise, but for cancellations that are not provided with 24-hours notice, or for a "no show," a cancellation fee of $75 will be charged.

Initials: _____

CO-PAY/COINSURANCE/DEDUCTIBLE: Co-pays, deductibles, and co-insurance is your responsibility, and payment is *due at the time of service*. The portion of charges that are your responsibility are based on your contract between yourself and insurer. Your insurer requires that we collect 100% of your financial responsibility under your contract; we are not permitted to wave or reduce charges unless there is proof of financial hardship. Initials: _____

PRIVATE PAY: Please be prepared to pay for services rendered at the time of service. This does include Kaiser Health Plans, Kaiser Medicaid, and Denver Health Medicaid. Initials: _____

STATEMENTS: We provide monthly statements to patients outlining the charges and claims activity. Upon receiving this, payment of statement balance is expected in full. If you have any questions regarding your statement, please contact our billing department.

Initials: _____

FINANCIAL PAYMENT ARRANGEMENTS: If you are financially unable to make payments in full, please contact our billing department to discuss a payment plan. You will be required to sign a Financial Payment Plan Agreement.

Initials: _____

RETURNED CHECKS: There is a $40.00 fee for any checks that are returned by the bank.

Initials: _____

COLLECTIONS: If payment is not received within two statement cycles (approximately 60 days from date of service), and/or you are not on an agreed-upon payment plan, your account is considered delinquent and will be referred to an outside collection agency. A patient cannot be seen in office until balance is resolved.

Initials: _____

AUTO/LIABILITY/WORKER'S COMPENASION: If you're presenting due to auto accident injury, we will bill your medical policy. It will be the auto policy's responsibility to reimburse the medical policy. If you're presenting with an injury resulting from another party's negligence, we will bill your medical policy. It will be the other involved party to reimburse the medical policy. If you're presenting with a workplace injury, please inform the receptionist immediately. You will need to contact your supervisor for instructions on how to file a worker's compensation claim and have proper paperwork present prior to being seen.

Initials: _____

PAYMENT REQUESTED PRIOR TO SERVICE: Certain surgeries or procedures will require pre-collection by our billing department. Our initial determination of your portion of financial responsibility prior to this service is preliminary and may be subject to adjustment when claims are processed by the insurer. We will send statements as soon as possible if there are changes found during claims filing. We reserve the right to reschedule or delay service if you are unable to make payment in full by time of service.

My signature below certifies that I have read, understand, and agree to the terms of this financial policy.

Name of Patient/Legal Guardian:_____

Signature: _____ Date: _____