

**Office Policies**

We are committed to providing you with the best possible care. In order to better serve you, KENTUCKY EAR, NOSE & THROAT has adopted the following policies. Please read and familiarize yourself with these policies so that future misunderstandings can be avoided. If you have questions, please do not hesitate to speak with the practice administrator.

- 1) If we participate with your insurance plan and it requires a referral, you will be held responsible to obtain a referral prior to your visit. All co-payments will be collected at the time of service. Please refer to your insurance company's provider directory to see if we participate with your plan.

\*Please remember. Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. You are personally responsible for any bill, or portion thereof, not paid by a third party insurance carrier or Medicare. Note: Hearing tests are frequently not covered by Medicare and other carriers.

- 2) If we do not participate with your insurance plan, you will be required to pay in full at the time of service, unless payment arrangements have been made prior to your visit. Our encounter form will serve as a receipt to submit to your insurance carrier.
- 3) We will file all third party insurances for surgical procedures. However, we will require any insurance deductibles and/or co-payments up to 20% be paid prior to the date of surgery.
- 4) For elective procedures not covered by insurance, payment in full is required prior to surgery.
- 5) A service fee of \$25.00 will be assessed for each returned check. Past due accounts may also be subject to attorney's fees, court costs, and other costs of collection.
- 6) In the event of repeatedly missed or broken appointments, the practice reserves the right to discharge a patient from its care.
- 7) For hearing aids dispensed by this office, payment in full is required when you pick up the device. You are entitled to a full refund minus the non-refundable fitting fees for up to 30 days from the time you pick up the aid.
- 8) I will allow photographs to be taken and used at the discretion of Kentucky Ear, Nose & Throat for treatment and educational purposes.

**PATIENT'S NAME:** \_\_\_\_\_

I have read the policies above and understand my responsibilities in exchange for medical care provided by Kentucky Ear, Nose and Throat.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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I Have Received The Privacy And Procedures Notice From Kentucky Ear, Nose and Throat.

**PATIENT'S NAME:** \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_