

Austin Ear Clinic

12201 Renfert Way, Suite #100, Austin, TX 78758 (512) 454-0341

FINANCIAL POLICY:

Thank you for choosing us as your health care provider. We are committed to the success of your treatment. Please understand that the payment of your bill is considered your responsibility. The following is a statement of our Financial Policy which we require that you read and sign prior to receiving any treatment in our clinic. In addition, all patients must complete and sign the Patient Information Form before being seen at the Austin Ear clinic.

INSURANCE BILLING:

We file insurance claims for companies in which we are providers. If your insurance company has not paid the claim within 60 days of filing, we require that you make a payment to your account. Your insurance policy is a contract between you and your insurance company. The charges due on your account are your responsibility, regardless of whether your insurance company pays your claim in a timely manner.

Full payment is due at the time of service. We accept cash, checks, Visa, Master Card and Discover credit cards for payment.

USUAL AND CUSTOMARY CHARGES:

Our practice is committed to providing the best treatment possible for our patients and we charge what is considered usual and customary for Otological and Neurotological specialties.

MINOR PATIENTS:

The adult accompanying a minor patient and/or the parents (or guardians) are responsible for full payment of the minor's treatment charges. An unaccompanied minor patient requiring non-emergency treatment will not be seen by our staff, unless the minor patient has written permission for treatment and charges have been pre-authorized by a deposit placed upon a valid credit card or check at the time of service.

Please let us know if you have any questions or concerns regarding our financial policy. We appreciate your understanding that we have instituted this financial policy in order to continue to provide quality patient care to all of the patients of the Austin Ear Clinic.

ACKNOWLEDGMENT:

I have read the Financial Policy above and agree to be seen as a patient of the Austin Ear Clinic, and therefore, accept the terms of said Financial Policy.

Printed Patient Name

Printed Parent or Guardian Name

Signature of Responsible Party

Date of Signature