WYOMING HEARING CLINIC

Patient Financial Policy

Patient Name: _____ DOB: _____

Thank you for choosing Wyoming Hearing Clinic! We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship.

Payment is Due at the Time of Service

- We accept cash, checks and debit.
- All co-payments, deductibles, co-insurance and fees for non-covered services are due at the time of service.
- Insurance-required co-payments are due when you check in for your appointment. If you arrive without your co-payment, we may ask you to reschedule.
- If your co-payment is based on a percentage (example: 20% of the allowed payment) and you do not have a secondary policy, please be prepared to pay a minimum of $50 on the date of service.
- Patient-responsible balances are due when you check in for your appointment.

Proof of Insurance

- Your insurance card(s) and a valid photo ID are required at the time of the appointment.
- It is your responsibility to notify the Practice of changes in your health insurance.

Self-Pay Accounts

- Self-pay patients, please be prepared to pay a minimum of $100 on the date of service. There may be additional fees for in-office procedures or services.

Referrals

If you have an HMO plan we are contracted with, you need referral authorization from your primary care physician. If we have not received authorization prior to your arrival at the office, call your primary care physician to obtain it. Without an insurance-required referral, the insurance company may deny payment for services. As such, if you are unable to obtain the referral at that time, you will be rescheduled or asked to pay for the visit in advance.

Divorce and Child Custody Cases

- In cases of divorce, the individual who receives care is responsible for payment of co-payments, co-insurance, deductibles and nonparticipating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.
- The parent who brings the child to the office for care is responsible for payment at the time of service, no matter if the account is self-pay, participating insurance or nonparticipating insurance. The Practice does not honor divorce specifics (e.g., percentage of financial responsibility).

No-Show/Cancellation Policy

- Please be advised that cancellations made less than 24 hours before a scheduled appointment will be subject to a $50 cancellation fee.
- Not showing up for your scheduled appointment will also result in a $50 no-show fee.
- The cancellation/no-show fee is **required** to be paid before another appointment can be made.
- If you are a no-show or cancel for three appointments, Wyoming Hearing Clinic will have the option of discharging you as a patient from the Practice.

____ I have read, understand and agree to the above No-Show/Cancellation Policy.

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Billing, Payments and Refunds

- If we must send you a statement, the balance is due in full within 14 days of the statement date.
- If you cannot pay the balance in full within 14 days, please contact our billing department to see if you qualify for special payment options.
- It is your responsibility to notify the office of any change in address, phone, employment or insurance coverage.
- If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same guarantor or financially responsible party.

____ We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action or terminate you as a patient of this Practice. I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

____ I authorize my insurance benefits to be paid directly to **Wyoming Hearing Clinic.**

____ I authorize **Wyoming Hearing Clinic**, through its appropriate personnel, to perform or have performed upon me or the above-named patient appropriate assessment and treatment procedures.

____ I authorize **Wyoming Hearing Clinic** to release to appropriate agencies any information acquired in the course of my or the above-named patient's examination and treatment.

Acknowledgment of Wyoming Hearing Clinic Notice of Financial Policy

I hereby acknowledge that I have reviewed, received or have been given the opportunity to receive a copy of **Wyoming Hearing Clinic's** Notice of Financial Policy.

X Patient/Guarantor Signature: _____ Date: _____