MinnesotaENT
EAR NOSE AND THROAT SPECIALISTS

Please carefully read and sign the following. If you have billing or financial questions, contact the business office at **763-233-5750**.

INSURANCE: Our clinic contracts with many health insurance companies. As contracted providers, we will submit claims for medical services to your insurance company. If you are unsure whether we are in-network with your plan, please **contact your insurance company.** If you have insurance coverage with a plan with which we are not contracted or if we are out-of-network, you are required to pay for services at the time they are rendered, regardless of any potential insurance reimbursement. In these situations, reimbursement typically goes directly to the patient rather than the provider. If we receive payment from both you and your insurance company, we will refund any overpayment to you.

SELF-PAY PATIENTS: If you do not have insurance or elect to waive insurance coverage, you are responsible for payment at the time services are rendered. We provide a discount only when payment is made in full on the day the services are provided.

GOOD FAITH ESTIMATE: A good faith estimate is required for all self-pay patients. Any patient may also request a good faith estimate. For services provided at a different facility (such as a hospital or surgery center), you must contact the facility directly to obtain a good faith estimate for their services, including facility fees, anesthesia, lab and pathology services.

REFERRALS: If your insurance requires a referral from your primary provider, you must obtain the referral prior to your visit.

PAYMENT FOR SERVICES: Copayments are due at the time services are rendered, as required by your insurance agreement. We will also request payment of any outstanding balance on your account at the time of your visit. We accept cash, check, CareCredit, MasterCard, VISA, Discover, and AmEx.

RETURNED PAYMENTS: A $35.00 fee will be charged for payments returned due to non-payment for any reason.

MEDICAL DEBT COLLECTION POLICY: Our policy is available on request or on our website at www.minnesotaent.com.

MEDICAID PATIENTS: You must have active, verified coverage on the date of service. If not, you will be considered a self-pay patient. We have direct access to the Minnesota DHS website to verify Medicaid coverage. If coverage is obtained retroactively, please call and we will refund any overpayment to you. We only accept Minnesota Medicaid coverage.

APPOINTMENT CANCELLATIONS: We require at least **one business day's notice** for appointment cancellations. Failure to provide this notice may result in a $75 cancellation fee, which must be paid in full before scheduling any future appointments.

SERVICES YOU MAY RECEIVE: During your office visit, the provider may perform diagnostic or therapeutic procedures to evaluate your condition. The most common procedures include the following: Hearing Test/Tympanometry, Endoscopy, Laryngoscopy, Nasal Cautery, and Earwax (cerumen) removal. These services are specific to otolaryngology and are not provided in general medical clinics. They are a routine part of the otolaryngology examination process and do not require written consent before being performed. Please note, these procedures are in addition to the evaluation and management fees. Your insurance may classify these procedures as "surgical" and process them at a different benefit level, which could result in additional copayments or apply toward your deductible.

If you do not wish to have any of these procedures performed, notify our staff prior to your visit.

NOTICE OF PRIVACY PRACTICES: I have been given or offered the Notice of Privacy Practices which is also available online.

RELEASE OF INFORMATION: I consent to the release of my health records and communication of medical information to physicians, providers, and staff as necessary for my treatment. I also consent to the release of health information to third parties, including Medicare or my insurance, for purposes of reviewing insurance authorization or claim payment processing.

MEDICATION HISTORY: I grant permission for access to and retrieval of my prescription medication history from the Surescripts network. This allows medication information to be viewed and used within my electronic health record.

ASSIGNMENT OF BENEFITS: I hereby assign my right to receive payment for Medicare or insurance covered services directly to Minnesota ENT. I authorize Minnesota ENT to submit claims to Medicare or my insurance on my behalf.

ELECTRONIC PAYMENTS: I hereby consent to the electronic processing of my checks for payment of services rendered. I understand that by providing a check as payment, I authorize the healthcare provider to process the check electronically.

CONSENT FOR TREATMENT: I voluntarily consent to diagnostic procedures and medical treatment by members of Minnesota ENT as necessary in my provider's professional judgment. I am aware that the practice of medicine is not an exact science and acknowledge no guarantees can be made about the result of such treatment.

PATIENT ACKNOWLEDGEMENT:

I HAVE REVIEWED AND UNDERSTAND THE POLICIES OUTLINED ABOVE AND AGREE TO COMPLY WITH THE TERMS.

Patient Name (*Please print)*: _____ Date of Birth: _____

Signature of Patient or Responsible Party: _____ Date: _____