6231 LEESBURG PIKE, SUITE 512, FALLS CHURCH, VIRGINIA 22044 (703) 536-1666 FAX (703) 536-5337
150 ELDN STREET, SUITE 235, HERNDON, VA 20170 (703) 707-0002
8644 SUITE 114 SUDLEY ROAD, MANASSAS VA 20110 (703) 330-6636
8314 TRAFORD LANE, SPRINGFIELD, VA 22152 (703) 569-0355

FINANCIAL POLICY

We know that choosing a physician is a very important decision and we thank you for choosing ENT Specialist of Northern Virginia/ Professional Hearing Services. Please take a minute to carefully read this overview of some of our financial policies.

INFORMATION REGARDING YOUR INSURANCE COVERAGE ___________ **INITIAL**

It is your responsibility to provide our office with all required information regarding your health insurance coverage. It is important that you promptly notify us if there are any changes. If your failure to timely provide this information or assistance results in a denial of coverage, you may (in certain circumstances) become personally responsible for paying for the services.

UNINSURED PATIENTS ___________ **INITIAL**

If you do not have current health insurance coverage, the entire payment for any services performed shall be paid at the time of service, unless other arrangements are made in advance.

TYPES OF PAYMENT; DISHONORED CHECKS ___________ **INITIAL**

Our office accepts Cash, personal checks, Visa and Master Card. If your check is dishonored or returned for insufficient funds, you will be required to pay an additional fee of $35.00.

COLLECTION OF OUTSTANDING BALANCES ___________ **INITIAL**

All outstanding balances shall be due within 30 days. Unless we have agreed to other payment arrangements in writing, it is important that you pay all past due balances, in their entirety, prior to or at the time of your visit. **Balances that remain outstanding for a period of 90 days or more may be referred to a collection agency or attorneys' office. If your account is referred to a collection agency, you will be responsible for paying a collection charge equal to 20% of your outstanding balance, which is in addition to your outstanding balance and any applicable interest**. If your account is referred to an outside attorney, you will be responsible for paying all reasonable attorneys' fees and court costs, which are in addition to your outstanding balance and any applicable interest.

MISSED APPOINTMENTS ___________ **INITIAL**

It is important that you appear for all scheduled appointments. By way of courtesy, we call to confirm your appointment a day or two before the scheduled appointment. If speaking to you is not possible for any reason, we attempt to leave a reminder message with a family member or on an answering machine/voicemail. If you fail to cancel or reschedule an appointment at least 24 hours (Hearing Aid Services) or 48 hours (Diagnostics Testing) prior to the visit you will be responsible for a paying a missed appointment fee of **$50.00** for Hearing Aid related services and/or **$100.00** for Diagnostic Testing.

RELEASE OF MEDICAL RECORDS ___________ **INITIAL**

Medical records created by our office shall only be released pursuant to your express written authorization in accordance with HIPAA or other controlling laws (or under other circumstances as required by law). In accordance with Virginia law, we charge a $10.00 research fee, postage and a photocopying fee of .50 cents per page up to 50 pages and then .25 cents for each additional page.

By signing below, the patient or responsible party acknowledges that he or she has read and understood the foregoing Financial Policy and agrees to be bound by the terms and conditions set forth therein.

_________________________________ _________________________

Signature of Patient or Responsible Party Date

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Print Name of Patient and Responsible Party (if any)

Revised: KAC 7/11/2014