DALLAS EAR INSTITUTE

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bills is considered a part of your treatment. The following is a statement of our financial policy, which we require you to read, agree to and sign prior to any treatment. Dr. Peters, Dr. Hahn and Dr. Dansby render only services that, in their best professional judgment, are needed to provide quality medical care for you.

PAYMENT IS DUE AT THE TIME OF SERVICE
We accept cash, checks, Visa or MasterCard

REGARDING INSURANCE

Our office is pleased to assist you in filing claims with your insurance company for reimbursement of these expenses. We will wait 45 days for your insurance company to pay your claim and if they do not we will give you 30 days to pay the balance.

- *The patient is responsible to pay any deductible and co-payments at the time services are rendered.*
- *It is your responsibility to know if a referral is necessary for your visit.*
- *Any portion of a billed amount that is labeled "disallowed" or "not covered" will become the patient's responsibility.*
- *Our office NEVER guarantees that your insurance will pay. We will make every attempt at the beginning of your health care to receive verification of your policy benefits. However, if for some reason your insurance claim is denied, you are responsible for the amount due on your account.*
- *Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. While we have an agreement with the Health Plan to provide services, any questions regarding coverage must be resolved by you with the insurance company.*
- *Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.*

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary.

NSF CHECKS

All returned checks will be assessed a $36.00 fee. All returned checks not paid in 15 days will be filed with the proper authorities.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to the provisions of this financial policy.

Signature of patient or person responsible for the bill *Date*