

Massachusetts ENT Associates, Inc.

Insurance Information Sheet

To avoid delays in processing claims, please provide the following information:

Patient name: _____

Referring doctor: _____

Patient's Social Security Number: _____

Primary Insurance Information

Insurance carrier: _____

Subscriber name: _____

Relationship to patient (circle one): self spouse father mother child

Subscriber social security number: _____

Subscriber date of birth: _____

Subscriber employer: _____

Secondary Insurance Information

Insurance carrier: _____

Subscriber name: _____

Relationship to patient (circle one): self spouse father mother child

Subscriber social security number: _____

Subscriber date of birth: _____

Subscriber employer: _____

Our Financial Policy

We are committed to providing you with best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- You must have your insurance card with you for each appointment.
- For patients with insurance with which we are participating/contracted with :
Copayments, deductibles, and co-insurance amounts are due at the time of service.
- Patients with non-participating/contracted insurances:
Full payment is expected at the time of service.
- Patients with insurance that requires a referral from a Primary Care Physician:
Referral must be in place on the date of service. Without this referral in place, full payment or rescheduling would be required.
- We accept cash, personal checks, Visa, and MasterCard
- Non-emergency treatment will be denied if:
 - A minor under eighteen is unaccompanied by an adult.
 - A patient with Medicaid coverage does not have a valid MASS HEALTH insurance card.
 - A “referral” is not obtainable when required by the patient’s insurance.
 - A patient has been delinquent on back payments and/or the account has been sent to our “Collection” agent.
 - A patient has missed more than three previous appointments and has been advised of being denied another appointment.

I hereby authorize Mass E.N.T. Associates to apply for benefits on my behalf for covered services rendered by them, or by their order. I request that payment from my insurance company and/or attorney, from PIP benefits or settlement proceeds, be made to Mass E.N.T. Associates.

I permit a copy of this form to be used in the place of the original.

I, _____, have read and understand the conditions
For payment to the Mass. E.N.T. Associates as outlined above. Date: _____

I understand that my insurance carrier may require a referral from my Primary Care Physician as authorization for treatment. It is my responsibility to obtain this referral. If a claim is denied by my insurance carrier for failure to obtain a referral, I will be held responsible for the full balance of the claim.

Signature _____ Date: _____

HIPAA

I acknowledge having received a copy of the practice's Notice of Privacy Practices

Signature _____ **Date** _____

Print your name _____