COLORADO SPRINGS
EAR ASSOCIATES

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Adult & Pediatric Ear Care - Hearing Aid & Cochlear Implant Center - Balance Disorders Center - Skull Base Surgery Center

PATIENT PROFILE				
PERSONAL INFORMATION				
First Name:	**Last Name:**	**DOB:**	**Age:**	
Phone Number:	**Email Address:**			**SSN:**
Mailing Address:		**City:**		**State/Zip:**
PROVIDER INFORMATION				
Referring Provider:		**Primary Care Physician:**		
FINANCIAL INFORMATION	**Current Balance:**			
Patient is financially responsible for their care: Yes_____ No_____		If No, please provide Guarantor information:		
Name:		**DOB:**		**Relationship:**
Phone Number:	**Email Address:**			**SSN:**
Mailing Address:		**City:**		**State/Zip:**

FINANCIAL POLICIES

1. Private Insurance: You are responsible for deductibles, copays, coinsurance, any non-covered services including out-of-network charges specific to your plan, and items considered not medically necessary by your insurance company. Copays and deductible amounts are due at time of service. Balances are due 30 days after receipt of payment from your insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted.

2. Private Pay: Please make payment for your care at each patient visit.

3. Medicare: Our office will submit your Medicare charges to Medicare and your secondary insurance, if applicable. You are responsible for co-insurance, co-pays, and any non-covered services.

4. Balances Due: Invoices are emailed immediately after your claim has been processed. Payment is due within 30 days of the invoice email date. Reminder emails will be sent 30 and 60 days after the invoice email date. A 5% late fee will be added to all invoices that are 60 days overdue. Unpaid invoice balances will be transferred to a debt collection service 90 days after the initial invoice email date. We can no longer accept payment for balances after an account has been transferred to a debt collection service.

5. Paperless Billing: Our offices do not mail paper invoices; we email invoices when balances are due. Patients may also log in to the Invoice Portal on our web sites to view their invoices and statements. Patients who choose to opt out of paperless billing will be charged a processing fee for each paper invoice mailed to them.

GUARANTEE OF PAYMENT

1. I understand that I am responsible for payment of all fees and services rendered, irrespective of insurance coverage or other responsibilities. **NOTE:** We will bill your primary insurance. If insurance does not pay in a timely manner (within 90 days from the date of service and insurance filing), the insured will be expected to pay the balance and then pursue reimbursement from the insurance company. I understand there is a $50 fee for any returned check for non-sufficient funds. **The guarantor of each account is ultimately responsible for payment in full of the account.**

2. I have been advised that if my commercial insurance carrier/HMO/Medicare plan claims that the services I receive from Colorado Springs Ear Associates are not considered reasonable and medically necessary for my care, I will be responsible for payment of these services.

3. I understand that my insurance plan may require my primary care physician to obtain an **authorization number** for the services that I receive from Dr. Hegarty. I have been advised that if I did not request a referral ***and*** authorization from my PCP in advance, my insurance plan may deny payment for services and I will be responsible for payment of all services.

4. I understand that it is my responsibility to determine if Joseph Hegarty, M.D. is a network physician for my **specific insurance plan** even if I have been advised that he is contracted with most commercial insurance companies. I understand that I may be responsible for paying out-of-network fees if relevant.

ASSIGNMENT

1. I assign the benefits from my insurance carriers to this office for the medical/surgical benefits to which I am entitled.

2. I request that payment of authorized Medicare benefits be made on my behalf to Colorado Springs Ear Associates for any service furnished to me by these providers.

RELEASE OF INFORMATION

1. I authorize Colorado Springs Ear Associates to release to my insurance carrier(s) any information needed to determine benefits payable for services.

2. I authorize Colorado Springs Ear Associates to release any information regarding my evaluation and treatment to my Referring/PC Providers.

3. I authorize any physician, hospital, laboratory or x-ray facility to release to Colorado Springs Ear Associates any and all medical information, hospital records, laboratory studies or x-rays that may be requested. A copy of this authorization is as binding as the original.

ACKNOWLEDGMENT OF RECEIPT OF FINANCIAL POLICIES

_____ (initial) **I have read and understand the Colorado Springs Ear Associates Financial Policies.**

I authorize Colorado Springs Ear Associates to discuss my private health information with the following persons:

Name: _____ Relationship:_____ Phone:_____

Name: _____ Relationship:_____ Phone:_____

_____ _____ _____

Signature of Patient | Email Address | Today's Date

_____ _____

Signature of Patient's Representative | Relationship