EASTERN SHORE ENT & Allergy ASSOCIATES, P.A.

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COLLECTION POLICIES, PROCEDURES, ACKNOWLEDGEMENTS & AGREEMENTS

Patient Name: _____ Date of Birth ____/____/____

ASSIGNMENT OF BENEFITS **-** I hereby authorize my insurance company(s) to make payment(s) as stipulated in my policy for any service furnished and that as such payment(s) be paid directly to the provider of service. I also understand that I am financially responsible for all services provided and agree to pay upon demand or as agreed for the related charges or remaining charges following my insurance payment(s).

CO-PAYS **-** I understand all co-pays will be collected at the time of service.

PRIOR BALANCES **-** All prior balances must be reconciled either by mail prior to, or at my next visit, whichever is sooner. The office accepts cash, check, money order, VISA, MASTERCARD and DISCOVER.

RETURNED CHECKS FEE **-** A $25.00 returned check fee will be applied to my account for all returned checks and we will NOT redeposit the check a second time. I will be required to pay the amount due by cash or money order.

MISSED APPOINTMENT FEE **-** I understand I may be charged a fee if I miss my appointment or do not cancel at least 48 hours prior to my appointment. This fee is not covered by my insurance carrier and must be paid prior to my next appointment.

COLLECTION FEES **-** I understand and acknowledge that if the patients account becomes delinquent (over 60 days), account balances (inclusive of all charges and reasonable collection costs including but not limited to reasonable collection agency/attorneys fees) may be sent to our collection agency/lawyer for legal collection action. The patient and/or guarantor or responsible party shall be responsible for and agree to pay all reasonable collection costs including but not limited to, reasonable collection agency fees, attorney's fees and court costs. In consideration of the acceptance of the patient named on this form by Eastern Shore ENT & Allergy Associates, PA and for services rendered or to be rendered to the patient, the undersigned promises to pay for and guarantees payment for all amounts due and any and all charges including collection costs described. If payments due are not made as agreed, Eastern Shore ENT & Allergy Associates, PA may, without notice or demand, declare the entire unpaid balance of the account including collection costs agreed to as described to be immediately due and payable. If court action is necessary to enforce payment, the venue for any such court action shall be Wicomico County, Maryland unless Provider elects otherwise. The undersigned waives any objection to venue or jurisdiction. A copy of this Agreement shall be made as valid as the original.

I HAVE READ, ACKNOWLEDGE AND AGREE TO ALL OF THE ABOVE COLLECTION POLICIES, PROCEDURES, ACKNOWLEDGEMENTS AND AGREEMENTS. Please print, sign and date below.

Patient/Guarantor Signature_____

Print Name _____Relationship to Patient: _____ Date: ___/___/___