EASTERN SHORE ENT & Allergy ASSOCIATES, P.A.

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COLLECTION POLICIES, PROCEDURES, ACKNOWLEDGEMENTS, AGREEMENTS & AUTHORIZATIONS

Patient Name _____ D.O.B. _____

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 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 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, checks, money orders, Visa, Mastercard and Discover.

RETURNED CHECK FEE—We will apply a $25.00 returned check fee to my account for all returned checks and will NOT redeposit the check a second time. I will be required to pay the amount due by cash or money order.

COLLECTION FEES—I understand and acknowledge that if a patient's account becomes delinquent (over 60 days), account balances (inclusive of all charges and reasonable collection costs, including but not limited to a reasonable collection agency/attorneys' fees) may be sent to our collection agency/lawyer for legal collection action. The patient, 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, attorneys' fees and court costs.

In consideration of the acceptance of the patient named on this form by Eastern Shore ENT & Allergy Associates, P.A., 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, P.A. 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 the 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.

PATIENT AUTHORIZATION—I authorize Eastern Shore ENT & Allergy, P.A. (ESENTA) to provide medical care and treatment to myself or the patient named above if they are under 18. I authorize ESENTA to apply for benefits on the patient's behalf for services rendered. I request the insurance make payments directly to ESENTA. I certify that the insurance coverage is correct. I further authorize the release of information, including medical information of any care or treatment of this or any related claims. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing prior to future treatment. My signature below indicates I have read and understand this authorization. I understand and agree to be fully responsible for the payment of any service provided, including deductibles, copayments and noncovered services at the time of service, unless other arrangements have been made.

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 _____

Revised December 2023