Richard B. Price, MD
Ear, Nose & Throat
Facial Cosmetic and Reconstructive Surgery

PAYMENT POLICY

Thank you for choosing Dr. Richard Price for your medical needs. We are committed to providing you with quality and affordable health care. This payment policy explains your financial responsibilities. Please read, let us know if you have any questions, and sign below.

1. **INSURANCE**: We participate in most insurance plans. If your insurance changes, please notify us immediately so we can make the appropriate changes to help you receive the maximum benefit. If your insurance doesn't pay your claims within a reasonable and customary amount of time, the balance will be your responsibility. Our office will do everything possible to receive payment of the claim, but in some cases the patient's involvement is required. Knowing your insurance benefits is your responsibility.
2. **CO-PAYMENTS AND DEDUCTIBLE**: Copayments may or may not be due at the time of service. Certain procedures performed by Dr. Price may be considered surgical by your insurance company. Once your insurance company has processed your claim, a copay may be assigned. We will then forward this to you. This arrangement is part of you contract with your insurance company. You are also responsible for your deductible.
3. **NON-COVERED SERVICES**: Please be aware that some, perhaps all, of the services you receive may be considered non-covered or not medically necessary by Medicare or your insurance. If this occurs, you will be responsible to pay this balance in full.
4. **CLAIM SUBMISSION**: We will submit your claims and assist you in any way reasonable to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not a party of that contract.
5. **SELF PAY AND COSMETIC**: Self pay patients are required to pay 100% fee for service at the time of visit. Payments for all cosmetic procedures performed in the office are due at the time of the visit. All outpatient cosmetic procedures must be paid in full 10 days prior to the date of service.
6. **NONPAYMENT:** Our office will make numerous attempts to collect unpaid balances by letters and/or phone calls to the responsible party with all of the information provided to us. Partial payments will be accepted **when an arrangement has been made with the billing office.** Should collection proceedings or other legal action become necessary to collect an overdue account, the patient and/or responsible party understands that Dr. Price has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient/responsible party understands that they are responsible for all cost of collection including but not limited to, all court costs and Attorney fees, and a collection fee will be added to the outstanding balance.
7. **MISSED APPOINTMENT**: It is important to notify us if you're unable to keep an appointment. Our office may charge for the second missed appointment. This charge is billed directly to you.
8. **RETURNED CHECK**: If your check written to Dr. Price is returned from your bank, there will be a $10.00 service charge. If the check is returned unpayable to our office from your bank, your will be responsible for original amount of the check, the initial $10.00 service fee and an additional $25.00 service charge. At this time, we will only be able to receive payment in the forms of cash, cashier check or credit card.

Our practice is committed to providing the best treatment to our patients. If you have questions regarding the HIPPA privacy act, please ask to review our privacy guidelines. We will assist you in any way to understand this policy. The fees charged by Dr. Price are respectful of the usual and customary charges set in our area by the government. Thank you for your understanding of our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines. I have completed the patient information sheet as accurately as possible.

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Patient/Responsible Party signature Date