OC EAR, NOSE, THROAT
HEAD & NECK SURGERY

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Financial Policy

I. Financial Policy

This is a statement of OCHNS' financial policy. You understand that you are obligated to ensure that our fees are paid in full. We will verify your coverage and bill your insurance carrier on your behalf. You agree that you will pay any deductible, co-payment, and/or co-insurance as determined by your insurance plan. Those payments will be due at the time of service. Many insurance companies have additional requirements or stipulations that may affect your coverage. You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to be responsible to pay the full balance. Claims not paid within 90 days will be made patient due; the patient will then need to contact the insurance company for further claims payment actions. Late fees/penalties may apply.

II. No Show/Cancellation Policy

OCHNS requires a minimum of 24-hour notice from our patients when canceling or rescheduling an appointment. Failure to cancel/reschedule before the 24 hour window will result in a $50 FEE per infraction (payable upon receipt of billing). Telephonic reminders are made by our staff when time permits. However, it is ultimately the patient's responsibility to remember scheduled appointments. You may leave notice of cancellations/re-schedules via phone 949-715-0500 but it must be at least 24 hours in advance of the appointment time. Please assist us in maintaining good service through efficiency.

III. Office Visits and In office Procedures

Office visits are considered as the evaluation of you by the physician. Any diagnostic materials/tools that are used during the office visit may be termed as a "Surgery" as outlined by the CPT guidelines by the American Medical Association. These can include, but are not limited to,: scopes used to visualize the throat , ear canals, or nasal passages, CT scans, ear cleanings, hearing tests, injections, allergy serums and the preparation, etc. The copay usually covers ONLY the office visit (consultation) and your deductible/co-insurance will apply to all other services that happen during the consultation.

IV. HIPAA (Health Insurance Portability and Accountability Act of 1996)

We disclose your protected health information to carry out treatment, payment, and health care operations. If you would like a more detailed description of such uses and disclosures, please refer to the Notice of Privacy Practices. You have the right to review the Notice of Privacy Practices before signing this consent form. The terms of the Notice of Privacy Practices may change from time to time. You can get a copy of the latest Notice of Privacy Practices by contacting our office. We also will post a copy of our current Notice of Privacy Practices in our office.
You have the right to request that we restrict how we use or disclose protected health information to carry out treatment, payment, or health care operations. We do not have to agree to such requests, but must honor the requests to which we agree. You have the right to revoke this consent in writing, and the revocation will become effective except to the extent that we acted in reliance on your consent.

My Acknowledgement

I have read and understand the financial and no show/cancellation policy described above. I agree to pay, promptly and in full, any amounts due to the provider, including co-payments, deductibles, surgery deposits, and amounts due for non-covered or services that are not payable by my insurance.

Patient Signature _____ **Date**_____