TEXOMA ENT & ALLERGY /TEXOMA HEARING INSTITUTE

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality and affordable health care. Please read the following policies.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we are contracted with, payment for your services is expected at your visit. Knowledge of your insurance benefits and eligibility is patient responsibility. If your insurance changes, it is your responsibility to notify us.
CO-PAYMENTS AND DEDUCTIBLES: All co-payments and deductible/co-insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company.
NON-COVERED SERVICES: Please be aware that some (and perhaps all) services provided may be, as described by your insurance company, non-covered or not considered reasonable or necessary by policy standards. You will be responsible for the total amount of these charges.
PROOF OF INSURANCE: We must obtain a copy of your driver's license and valid insurance cards. If you fail to provide us with this information, you will be considered responsible for the balance, or your appointment rescheduled.
FORMS: If a specific form needs to be completed, there may be a $30.00 fee due and payable before the form is completed (i.e. FMLA).
MISSED APPOINTMENTS: To avoid a $25.00 cancellation fee, please give us 24 hours advance notice when cancelling appointments.

I authorize this practice to contact me via current and any future cellular phone number(s), email address, or wireless device(s). I authorize its agents, representatives, and attorneys (including collection agencies) to use automated telephone dialing equipment, artificial or pre-recorded voice or text messages and personal calls and emails, in their effort to contact me for purposes of collecting any portion of my account which is past due or scheduling issues.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of any medical information needed to process a claim. I also authorize the release of medical benefits directly to the physician for services described.

I hereby authorize this practice to furnish medical information pertinent to my medical condition including, but not limited to the diagnosis, treatment and care offered or rendered to me in regards to referrals, hospitalization and/or further testing. I agree not to hold Texoma ENT & Allergy/Texoma Hearing Institute, its agents and/or employees, liable for any unfavorable outcomes as a result of releasing this information. I understand I can revoke this authorization at any time, (in writing).

I have read, reviewed and understand the above: including payment policy, insurance requirements (copays, deductible and coinsurance), non-covered services, my responsibility to notify of any coverage changes, missed appointments, authorization to contact me by the above listed devices and authorization to release information. My signature below acknowledges my agreement.

Signature of patient or responsible party _____ Date _____

PRINT Patient Name _____ Account # _____

Revised 04/10/2019