



Patrick J Chiles MD
Eric K Fung MD
Amy L Reynders MD
Rebecca A Sleeper RNNP
Erinn White MD
Melissa Giufre PA

FINANCIAL POLICY

SELF-PAY:

Payment for services provided in the office requires **\$100 deposit at the time of check in**. You will then be required to pay the remainder of your bill at check out (after you have seen a provider) based on the service that were provided to you that same day. If your balance is excessive, you **MUST** speak with a billing representative to make payment arrangements **BEFORE** you leave our offices. For your convenience, we accept cash, check, Visa, Master Card, Discover, American Express and Care Credit. A receipt will be given to all patients who have made a payment.

PATIENTS WITH INSURANCE:

Please bring your insurance card to **each** visit for eligibility verification by our staff.

Patients who do not have their insurance card at the time of the visit will be billed directly. (unless insurance verification for payment prior to or on the date of service).

If your insurance does not respond within 60 days, the balance will become your responsibility.

CO-PAYMENTS:

Co-payments will be collected at the time of service. We accept cash, check, Visa, Master Card, Discover, American Express and Care Credit. Please make every effort to pay your co-payment at your appointment. Our practice has contractually agreed with your insurance company to collect co-pays at the time of your visit. If your insurance carrier does not respond within 60 days, the balance will become your responsibility.

OUT OF NETWORK PLANS:

You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's usual, customary and reasonable charges. All patients will be responsible for their co-insurance/deductible. If we do not participate with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days; you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to our office.

BILLING QUESTIONS:

We realize special circumstances may arise and will assist you in every way we can.

Please understand we reserve the right to report **delinquent accounts of more than 90 days** to the credit bureau after all efforts have been exhausted to obtain payment.

Failure to remit payment towards the balance due within 90 days or have an established recurring payment arrangement may result in discharge from the practice. **Please feel free to contact the billing department at (315) 251-1093, option 5 with questions.**

NO-FAULT/WORKERS COMPENSATION:

You are responsible for providing our office with the necessary information needed to properly submit charges. If you fail to do so, the fees mandated by NY State will be changed to reflect our standard fees and you will be responsible for payment. Some No-Fault carriers have deductibles on medical charges, for which the **patient** (NOT THE INSURED) is responsible. If you have private insurance, we will submit on your behalf and bill you for any unpaid balances.

LIABILITY:

Carriers usually remit payment to the patient or to the patient's attorney if one has been retained. Our policy does not allow us to hold accounts which are pending resolution of any liability or litigation issues. If you provide a letter from the liability carrier indicating they accept full responsibility and will remit payment, we will submit on your behalf. Otherwise, you may either have charges submitted to your private carrier or pay for services and obtain reimbursement upon resolution/settlement.

DISABILITY FORM COMPLETION:

Please note: We reserve the right to charge a flat fee of \$10.00 per request as an administrative fee for filling out disability paperwork, including FMLA forms. This fee is due at the time of the request.

DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS:

The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Syracuse ENT Surgeons will not be involved in separation or divorce disputes.

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS/INFORMATION RELEASE:

By signing this form, I authorize payment of medical benefits to Syracuse ENT Surgeons for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

If you need further explanation of any of the above policies, please contact our Billing Office or the Practice Manager. Thank you for your cooperation.

3906 East Genesee Street, Dewitt, NY 13214
Phone: (315) 251-1093 Fax: (315) 251-1571