



NORTHWEST EAR INSTITUTE, PC

H. HAROLD KIM, MD

2230 NW PETTYGROVE, STE 120 PORTLAND, OR 97210

FINANCIAL AGREEMENT

Thank you for choosing Northwest Ear Institute as your healthcare provider. We are committed to providing you the best possible medical care. Please understand that payment of your bill is considered part of your care plan. Please read and familiarize yourself with this policy so that any future misunderstanding can be avoided.

- We will verify with you your insurance coverage at every visit. It is the patient's responsibility to supply all current insurance cards.
We will ask you for a copy of your driver's license or other picture identification issued from the DMV for identity verification.
If you do not have insurance or cannot provide proof of insurance at the time of service, a pre-payment of \$75.00 will be required before services are provided except in the case of emergency.
A \$5.00 fee will be assessed for any co-payments not made at the time of service. We also charge a \$10.00 fee for re-billing insurance and/or billing insurance not provided to us at the time of service.
We accept cash, checks, Visa, MasterCard, Discover, American Express and CareCredit. A \$25.00 fee will be assessed for any returned checks.
Payment plans can be arranged with the billing office. Any accounts over 90 days will receive a \$5.00 billing fee per month until the account is paid in full.
If your insurance company requires a referral from your Primary Care Physician (PCP) to see a specialist, it is your responsibility to obtain a referral/authorization prior to your appointment. ANY UNAUTHORIZED CHARGES WILL BE YOUR RESPONSIBILITY.
The adult accompanying a minor to a visit and the legal parents/guardians are responsible for full payment. We will not be involved in negotiating between parents in custody disputes.
As a specialty office, it is necessary for us to perform diagnostic services such as hearing tests to provide you with the highest quality of ENT care. There is a separate charge for each of these services and all insurances can cover them differently. We highly recommend that you contact your insurance carrier with any questions that you may have regarding your coverage of these services.
There will be three separate monthly billing statements sent to the provided address. After three statements, all outstanding amounts will be AUTIOMATICALLY sent to a collection agency unless a previous payment plan has been agreed upon.

As a courtesy to our patients, we will submit claims to your insurance carrier for you. For those plans that we participate in, we will also submit secondary and/ or tertiary claims. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered by your plan or how it will be covered by your plan. The patient is responsible for knowing the details/rules of their health plans(s) as we cannot change our coding in attempt to obtain payment.

I hereby authorize Northwest Ear Institute, PC to release any medical information required in the course of examination and treatment and permit payment directly to them from any benefits due to their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes, but is not limited to, co-payment, co-insurance, deductible and non-covered services.

I have read, understand, and agree to the Financial Policy (above).

Name of Patient or Responsible Party (Print)

Relationship to Patient

Signature of Patient or Responsible Party

Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received the Notice of Privacy Practices for Northwest Ear Institute, PC

Signature of Patient or Responsible Party

Date