



Ear Nose & Throat  
CONSULTANTS, LLC

Phone: 402-778-5250

Fax: 402-778-5216

FINANCIAL POLICY

Thank you for choosing Ear, Nose & Throat Consultants, LLC for your health care needs. All patients must accept our FINANCIAL POLICY before receiving treatment. Please understand that full payment of your bill is considered a part of your treatment.

1. We accept **CASH, CHECKS, VISA, MASTERCARD, DISCOVER, CARE CREDIT and AMERICAN EXPRESS.**
2. **Co-payments as well as outstanding balances** are always due at the time of service, unless other arrangements have been made with the billing office. Our contractual agreement with your insurance carrier prevents us from waiving your required co-pay amount.
3. The balance of the account is **due within 15 days of the statement date** unless you have made other arrangements with the business office. An **Administration fee of \$10.00** will be applied to your account if full payment is not received by the statement due date. We will collect all outstanding account balances prior to each visit.
4. If you have **no insurance coverage, payment of 80% of charged fees are due at the time of the visit with a minimum payment of \$150.**
5. **Routine diagnostic procedures** that are customary to our specialty and are a necessary part of your treatment may be applied toward your deductible or coinsurance depending on your individual insurance plan. It is the responsibility of the patient to know their coverage details.
6. Payment for **elective services** will be required 48 hours prior to service and will not be filed with your insurance company until after they are rendered.
7. A **\$25.00 service charge** will be assessed for returned checks. If your check is returned, you will be required to pre-pay in full by cash, Visa, MasterCard, Discover, or American Express for additional services.
8. **Call to correct any billing errors promptly.** If you ignore our billing statements or telephone calls, we can only assume that you do not intend to pay for the medical services that were provided in good faith, and your account will be forwarded to an outside collection agency.
9. **Referrals** – some insurance plans require that a referral from the primary care physician be obtained prior to being seen. It is the responsibility of the patient to obtain this referral. If a referral has not been obtained you may be responsible for a larger portion of your bill.
10. **Personal Injury** – we will not be a party to any litigation suits filed for personal injuries. We require payment in full and any payment from litigation is to be sought by you for reimbursement.
11. **Work-Related Injuries** – pre-authorizations for care is the responsibility of the patient. If the prior authorization is not obtained, you are responsible for full payment at the time of service. If your workers compensation carrier has not paid your account within 45 days of the date of service, the owed balance will become the responsibility of the patient.

I UNDERSTAND AND AGREE TO THE TERMS OF THIS FINANCIAL POLICY.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Signature of Patient or Patient Representative

\_\_\_\_\_  
Date



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### Procedures in office

Your Primary Care Physician referred you to a specialist because we have specialized equipment to diagnose and treat you. Please be aware that certain procedures performed in our office are not included in the standard office visit. These procedures will be billed separately and in addition to the office visit charges. **Insurance carriers often classify these procedures as surgery and apply the charges to your calendar year deductible.** This is plan specific with your insurance. High deductible plans may apply patient responsibility for both the office visit and the procedure. Traditional plans may apply a copayment for the office visit, and deductible for any procedures. In such cases, payment of the procedure will be due from the patient. Be assured that we are following all federally accepted billing and coding guidelines.

The physicians of ENT Consultants only perform procedures when deemed medically necessary to best diagnose and treat our patients. If you are presenting with sinus, throat/voice complaints, or have had past sinus surgery, there is a good chance that our providers will determine it necessary to perform one of these procedures to properly diagnosis and treat you.

Examples of in-office procedures and their estimated costs include:

- CPT 31231 Nasal Endoscopy \$515.00
  - This procedure uses a flexible or rigid scope attached to a light source to view areas of the nasal cavities that cannot be viewed by the physician using the nasal speculum and head mirror.
- CPT 31575 Flexible Laryngoscopy \$335.00
  - This procedure involves passing a long thin flexible fiber optic scope through the nasal cavity and into the throat. Their fiber optic scope enables the physician to visualize areas of the throat not readily seen using laryngeal mirrors.

This list is not inclusive of all procedures that may be performed in our office.

Patient Name (Please print): \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## Notice of Privacy Practices & Alternate Communications

*The Notice of Privacy Practice describes how medical/protected health information about you may be used and disclosed and how you can get access to this information.*

In summary, as a patient you have the right to access your protected health information. You also have the right to request corrections to your information, request your information be restricted, and request confidential communication. We want to assure you that your medical/protected health information is secure with us. You also have a right to request a detailed Notice of Privacy Practice of the Medical Practice named at the top of this page at any time.

\*\*\*In accordance with my right for protected health information, I give you permission to discuss my protected health information with the following people (please include name, relationship, and phone number):

| NAME | RELATION | CONTACT INFORMATION |
|------|----------|---------------------|
|      |          |                     |
|      |          |                     |
|      |          |                     |

\*\*\*In accordance with my right for protected health information, my preferred method of communication is:

Phone: \_\_\_\_\_  Patient Portal (see receptionist)  Postal mail

\*\*\*Can we leave a message on this phone number?  Yes  No

In the event that we are unable to contact you via your preferred method of communication, how do you want to be contacted?

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I acknowledge that I was notified of my HIPAA rights and my right to obtain its full details. I also have exercised my right to name or not name any alternate individuals to receive my protected health information as well as indicated my preferences regarding how I would like to receive my protected health information.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Signature of Patient or Patient Representative

\_\_\_\_\_  
Date



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**ENT CONSULTANTS, LLC – RETURN VISIT MEDICAL HISTORY UPDATE**

**\*\*\*This information is needed to ensure that you receive the best care possible. Please fill out completely. If anyfield is left blank, it will be assumed that the answer is "NO."\*\*\***

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

DOB: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

If female, are you or could you be pregnant? YES NO

PLEASE PROVIDE THE DATE OF THE FOLLOWING TESTS/VACCINES SINCE YOUR LAST VISIT:

DATE OF LAST PAP SMEAR: \_\_\_\_\_

DATE OF LAST MAMMOGRAM: \_\_\_\_\_

DATE OF LAST COLONOSCOPY: \_\_\_\_\_

DATE OF LAST FLU VACCINE: \_\_\_\_\_

DATE OF LAST PNEUMONIA VACCINE: \_\_\_\_\_

DATE OF LAST COVID-19 VACCINE: \_\_\_\_\_

Manufacturer (Please Circle): Pfizer Moderna Johnson and Johnson

\*\*\*HAS YOUR GENERAL MEDICAL HISTORY CHANGED SINCE YOUR LAST VISIT? Yes No

If yes, please indicate? \_\_\_\_\_

\*\*\*HAS YOUR FAMILY MEDICAL HISTORY CHANGED SINCE YOUR LAST VISIT? Yes No

If yes, please indicate? \_\_\_\_\_

\*\*\*HAS YOUR SOCIAL MEDICAL HISTORY CHANGED SINCE YOUR LAST VISIT? Yes No

If yes, please indicate? \_\_\_\_\_

\*\*\*HAS YOUR MEDICATION LIST OR MEDICATION ALLERGIES CHANGED SINCE YOUR LAST VISIT? Yes No

If yes, please indicate? \_\_\_\_\_

\*\*\*HAS YOUR PHARMACY CHANGED, PLEASE INDICATE: \_\_\_\_\_