severn river ENT
Plastic and Laser Surgery

PAYMENT TERMS / FINANCIAL RESPONSIBILITY AGREEMENT

I authorize my insurance provider(s) to pay the proceeds to any benefits on my behalf directly to Lee A. Kleiman, M.D., doing business as Severn River ENT, Facial and Plastic Surgery. I agree to pay promptly any deductibles, co-insurance or co-pays that are determined by my insurance provider(s) to be my responsibility. I understand that office co-pays are due at the time of visit. Any additional payments due will be made without delay, upon receipt of a statement. If any balances remain open and it is necessary to refer my account for collection, I agree to be responsible for all cost of collection including attorney fees of 25% of any balance.

I further understand that it is my responsibility to obtain a referral from my primary care physician if my insurance requires one. I understand that if I do not have a valid referral at the time of my appointment, that I will have to reschedule my appointment. Should I be seen without a valid referral and payment is denied by insurance, any claims denied will be my responsibility to pay.

FEDERAL BCBS DISCOLSURE & FINANCIAL AGREEMENT

Dr. Kleiman feels that a patient presenting to our office with sinus, allergy, throat, or voice complaints require a thorough examination of that specific area. In some case cases, this can only be accomplished through the use of an endoscopy. A **"procedural fee"** will be submitted to your insurance carrier for this procedure. Patients are obligated to pay any deductible and/or co-payments that are applied to this claim. Please note, some insurance companies may list the endoscopy as a "surgery" on your Explanation of Benefits (EOB).

HIPPA NOTICE OF PRIVACY PRACTICES AKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow up among the healthcare providers who may be involved in my care directly/indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physical certifications.

I understand that this practice has the right to change its "Notice of Privacy and Practices" and that I may contact this organization at any time to obtain a copy of its most current copy of the policy. I understand that I may request in writing that you restrict operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____

Patient Signature (Parent, Guardian or Legal Guarantor if applicable) Date

I authorize my medical records and/or medical information to be released to the following individual(s):

Name: _____ Relationship_____

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Missed Appointment Fees

I understand that there is a **2 BUSINESS DAY** requirement to cancel or re-schedule an appointment. Failure to do so may result in a **non-refundable** missed appointment fee. Furthermore, if you miss your appointment, you will be assessed a fee. Our fees are as outlined below.

- $25 fee for all “non-procedure” appointments.
- $50 fee for all “procedural” appointments, such as a videostrobe appointment.
- Cosmetic treatments will loose the deposit made. The amount varies and specific to the cosmetic treatment you are scheduled for.
- $50 fee for all Groupon clients. For multi-treatment services, a treatment will be deducted from your series purchased.

I agree and understand to the terms as stated above. I understand that the fee is **non-refundable** and will not be applied towards the cost of any future appointments and/or treatments.

_____ _____

Patient Signature (Parent, Guardian or Legal Guarantor if applicable) Date