**Anne Arundel ENT &**
**Facial Plastic Surgery**
**600 Ridgely Avenue, Suite 110**
**Annapolis, MD 21401**
**(410) 573-9191**
**(410) 573-5910 Fax**

**Financial Agreement**

As of February 1, 2008, the following applies:

**Co-Pays**

Co-pays are due at the time of the visit. We do not bill for co-pays. If you cannot pay your co-pay at the time of your visit, we may have to reschedule your appointment.

**Missed Appointment Fees**

I understand that there is a $25.00 fee for any missed "non-procedure" appointments.

There is a $50.00 fee for any missed "procedure" appointments.

Dr. Meek, Dr. Kleiman and Dr. Wachal feel that a patient presenting to our office with sinus, allergy, throat, or voice complaints require a thorough examination of that specific area. In some cases, this can only be accomplished through the use of an endoscope. This examination is essentially painless and, in many cases, can be accomplished quickly. A "procedural fee" will be submitted to your insurance carrier for this procedure. In most cases, we will accept your insurance company's allowance for this procedure. You will be obligated to pay any deductible and/or co-payments that are applied to this claim. (Please note, some insurance companies may list this diagnostic procedure as "surgery" on the insurance remittance advice you receive) These procedures have almost no risk and provide your physician with an excellent view of the areas involved. Please sign below to acknowledge that you have read the above and agree to undergo this procedure.
24 hour notice is required for any cancellation to avoid being charged the above noted fees.

I understand that it is my responsibility to notify Anne Arundel ENT & Facial Plastic Surgery if my insurance has changed. If I fail to do so in a timely manner and my insurance fails to process my claim for payment due to the timely filing restrictions, I will be financially responsible for the visit cost in full.

Any patients arriving more than 15 minutes late to their appointment, without prior notice to our office, will result in the forfeit of their appointment time. Your appointment will be rescheduled at the next available opening, which is not guaranteed to be the same day.

I have ready and fully understand this financial agreement. I acknowledge copays are due at the time of my visit and that I will be charged for any missed appointments, along with any and all financial balances left by my insurance. If balances remain open and it is necessary to refer the account for collection, I agree to be responsible for all costs of collection including attorney fees of twenty-five percent (25%) of any balance due.

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Patient signature (or guardian if patient is a minor) Date