Clove Lakes
EAR NOSE AND THROAT AND LASER CENTER

Specializing in Adult & Pediatric Ear, Nose, Throat & Allergy Sinus Surgery, Head & Neck Surgery

Staten Island
1414 Victory Boulevard, Staten Island, N.Y. 10301

Bay Ridge, Brooklyn
250 86th St Brooklyn, N.Y. 11209

Phone: (718) 447-1261
Fax: (718) 981-1856
www.clovelakesent.com

Helen H. Kim, M.D.
Board Certified in Oncology-Head & Neck Surgery

Santa Upeniece PA-C

Clove Lakes ENT, P.C.

Financial Policy, Revised 2/1/2016

Our office participates in many health insurance plans. Even if Dr. Helen H. Kim is identified as participating in your plan, it is important for you to know that individual health plans vary. We will submit all claims to your Company Insurance; it may not be covered at all by your particular coverage. It is your responsibility to understand and know your benefit plan. You should contact your Insurance Company if you have any questions related to a specific treatment or visit and your financial obligations.

For your convenience we accept payment in the form of cash, check, and major credit cards (VISA AND MASTERCARD, AND DISCOVER, ONLY) and debit cards (with VISA or MASTERCARD logos). If you have a concern regarding your ability to pay for treatment please ask to speak to our Billing Manager prior to being seen.

Thank you for choosing Clove Lakes ENT.

1. On arrival, please sign in at the front desk and present your current insurance card. If the Insurance Company that you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.
2. **According to your insurance plan, you are responsible for any and all co-payments, deductibles and coinsurances.**
3. We do submit to secondary Insurance plans. If you have secondary insurance, please provide us with the secondary insurance card. **If secondary insurance will not pay, you are responsible for remaining balance. If secondary insurance has deductible you are responsible for this.**
4. It is your responsibility to understand your benefit plan.
5. For scheduled appointments, prior balances must be addressed prior to the visit.
6. If you have no insurance, payment for services is expected at the time of visit.
7. Co-payments are due at the time of service. A **$10.00 processing fee** will be charged in addition to your co-payment if not paid at time of service.
8. Patient balances are billed immediately on receipt of your insurance plans explanation of benefits. Your remittance is due within 10 business days of receipt of your bill.
9. If previous arrangements have not been made with our office billing department, any balance over 60 days old will be forwarded to a collection agency.
10. A **24 hour** notice for canceling any appointments. There is a **$25 charge** for appointments not cancelled within that time frame or for no-shows.
11. All scheduled testing appointments (ex: hearing tests, balance tests, cat scans, etc.) require a **48 hour** cancellation notice. There is a **$75.00 charge** for all testing appointments that are not cancelled within that time frame or for no-shows.
12. Also, if you are scheduled for surgery you MUST cancel 72 hours prior to scheduled date or else you will be charged a **$75.00 fee.**
13. A **$35 fee** will be charged for any bounced checks returned by your bank.
14. We charge a **$25 fee** for Disability forms or other similar forms to be filled out, and a fee for requests of medical records. There is also a **$25 fee** for imaging medical records.
15. There is a **$10 charge** for requested copies of CAT-SCAN CD's, when the CAT-SCAN was performed here in our office.
16. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

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I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

Patient name (PLEASE PRINT) _____

Responsible party name (IF NOT THE PATIENT): _____

Relationship to the patient: (Please Circle one) Self Parent Spouse Other

Signature: _____ Date: _____