Lakeside ENT Financial Policy

Patient Name: _____DOB:_____

Email Address for Portal Registration: _____

Thank you for choosing Lakeside ENT & Allergy! We are committed to the success of your medical treatment and care. This financial policy helps us provide quality care to our valued patients. If you have any questions or need clarification of any of the below policies, please feel free to contact our billing department.

As of January 1st, 2022, the No Surprise Act will take effect. For a copy of this policy, or to sign up for our patient portal, please see our Front Desk Associates or visit our website at www.lakeside-ent.com

Health Insurance Plan Participation

Lakeside ENT & Allergy (LENT) participates major insurance plans such as Excellus BCBS, MVP, Aetna Health, United Health Care, Medicare, and many other commercial insurance plans. We suggest that you please contact your insurance company to understand your in and out-of-network coverage.

If you have Medical Insurance Benefits, please bring your insurance card with you!
If you change insurance plans, please notify the office immediately.
It is the patient s responsibility to provide all necessary information before leaving the office.

Co-Payments

Your insurance plan requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state/federal law. Help us help you by paying your co-payment at each visit. We accept cash, checks, Visa, MasterCard, American Express, Discover and Care Credit.

Co-Insurance

You are responsible for a contracted percent (co-insurance) for all services, office visits, procedures, etc. at LENT. After your insurance has made a payment determination, you will be billed by LENT for your financial responsibilities. ***You are also responsible for any balance remaining on your account for services rendered.***

Non-Covered and Out of Network Services

Payment for medical services that are considered by your insurance company to be non-covered, out of network, or not medically necessary will be your responsibility. We recommend that you verify your insurance coverage prior to treatment and fully understand the financial responsibility (out of pocket expenses) your policy sets forth.

PROCEDURES/SURGERIES: Feel free to inquire about pricing. We can provide a Good Faith Estimate to you within 3 business days.

Referrals

If you have an HMO plan that contracts with us, you need a referral from your primary care physician. If we have not received a referral prior to your arrival at the office, please call your primary care physician to obtain it. Without an insurance required referral, the insurance company will deny payment for services. If you are unable to obtain the referral, you will be rescheduled or asked to pay for the visit in advance. **If you have insurance through the VA, United Health Care Community Plan, Blue Cross & Blue Shield of Western NY with prefix WNH – you must obtain a referral prior to being seen.**

If You Do Not Have Medical Insurance

Payment for all professional services is expected at the time of your visit. Please contact the office for the fees for your visit or to obtain a Good Faith Estimate. We offer a 20% discount for Self-Pay patients.

Services Billed Separately

Some of the services you may receive in conjunction with your care by Lakeside ENT & Allergy are not included in the charges billed by LENT; you may be billed separately for them. They include hospitals, ambulatory centers, x-rays, radiologists, labs and anesthesiologists. They may, or may not, participate with the same plans as Lakeside ENT & Allergy. Please check with those other providers if you have questions regarding the insurance plans they participate with or a bill you may receive from them.
LENT is always available to provide specific information on our own fees, please ask our billing department.

Office Procedures

Procedures are billed separately, and in addition to, office visit charges. Some insurance policies classify office procedures as **"Surgery"**. Office procedure (surgery) can incur additional co-payments or an out-of-pocket expense.
When seeing a Specialist, it is ***very likely*** that your provider will perform a diagnostic procedure essential in managing your medical condition. Your insurance carrier may define them as a "surgical procedure". Your explanation of benefits may reflect the use of this term and ***you may have additional co-payment or deductible charges*** for these procedures.

POST OP "Global" Period

Some office and/or surgery procedures have a "global period". This means the fee for that service covers routine post-operative care for a limited number of days. However, if a different diagnosis is treated within that period, this is a separate billable service.

Payment Plan

Please let us know if you are having difficulty paying your account. We may be able to help you by setting up a payment plan. Please call 585-394-8800 for assistance.

Missed Appointments, No-Shows, and Cancellations

We require **24-hour prior notice for cancellation of office appointments**. Cancellations without **24-hour** notice **will be charged $50.00**. We require **72 hours prior notice for cancellation of surgical procedures** (Hospital or Office). Cancellations without **72 hours** prior notice **will be charged $150**. All missed appointments without prior cancellation are considered "no-show". Patients who consistently no-show to appointments are at risk of being limited to emergency care only or dismissed from the Practice.

Delinquent Balance/Collections

If you receive a statement, please note that the balance is due in full upon receipt.

It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage.

If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same guarantor or financial responsible party.

We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, or terminate you as a patient of this Practice.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. I authorize my insurance benefits to be paid directly to Lakeside ENT & Allergy.

X Patient/Guarantor Signature: _____ Date: _____

I authorize Lakeside ENT & Allergy to contact or discuss my personal health information with the following people only:

Name:	Relationship:	Contact #:
Name:	Relationship:	Contact #: