Financial Policy

Copay Policy:

Copayments are due and will be collected at the time of your visit.

Payment Plan Policy:

We are committed to cost-effectively delivering safe, high-quality care. As part of that commitment to help you and your family with these bills, we have an online payment option that allows you to pay the bill in full. ***Payment on unpaid balances is expected within 30 days of your first statement.*** Any missed payments on a payment plan must be paid in full to be considered in good standing.

Our Payment Plan Agreement option provides you with flexibility and affordability to pay the costs for your procedure.

The features of our Payment Plan Agreement include:

- Zero-interest and an APR of 0% for the life of the plan
- Monthly payments can be made online, or you can choose to schedule recurring payments from your bank account or credit card for your convenience
- Ability to select a preferred payment day of the month
- No fee for early payoff
- A cash down payment may be required at the time you sign a Payment Plan Agreement

The Terms of the Payment Plan Agreement:

Balance	Payment Terms
Less than $600	$50 per month, up to 12 months
$600 - $1200	$100 per month, up to 12 months
Greater than $1200	Total amount divided by 12 = monthly payment amount.

*Professional Hearing Services Payment Plan Requirements:

Payments of non-covered services follow the above payment program, however; to be eligible for platinum care supplies, drop off services, and/or service plan visits, the account must be in good standing. Those patients who fail to meet the designated requirements of payment plans or who maintain outstanding balances in default status, are not eligible to receive these services until the account is in good standing. An account in good standing may require payment of multiple missed payments to satisfy the current agreement.

Insurance Authorization & Assignment:

I request that payment of authorized medical benefits is made on my behalf directly to the Moreland ENT and/or PHS provider of service(s) furnished to me. I authorize Moreland ENT and/or PHS to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to Moreland ENT and/or PHS. I hereby authorize that any photocopies of this form to be valid as the original.

Patient Signature or Personal Representative

Date of Signature