Naugatuck Valley Ear, Nose and Throat Associates LLC

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

Patient Name:_____

Chart Number:_____ Date of Birth:_____

I accept full financial responsibility for any charges incurred today if:

1. The services rendered or supplies used/purchased are not covered under my Insurance Plan;
2. My insurance plan requires that I pay a deductible, co-payment, or there is a co-insurance;
3. There are charges that have resulted because I have failed to provider current and valid insurance policy information; or
4. My insurance plan requires that I obtain a referral prior to my visit and I do not have one in place.

I agree:

1. That payment be made to Naugatuck Valley Ear, Nose and Throat Associates LLC. (NVENT) by my insurance carrier for services rendered or product received;
2. And I under stand that NVENT may use and disclose medical information about me for services and procedures so they may be billed and collected from an insurance agency or any third party;
3. to pay for my co-pay and other charges that are not covered by my insurance carrier today or make financial arrangements satisfactory to NVENT for payment;
4. To pay for any returned check fees incurred by NVENT;
5. If I am the parent/guardian bringing a child for treatment, that I am responsible for all fees incurred by the child;
6. If an account is sent to collection or attorney for collection, to pay collection expenses and attorney's fees.

Date:_____

Patient Signature: _____ Parent/Guardian Signature:_____ _____