Payment Policies

Patient Name:_____ **Date of Birth**:_____ **Account#**_____

____Initial **Insurance Information**: Insurance card(s) must be presented at the time of service. A copy of your insurance card(s) will be made for your file. It is your responsibility to provide updated insurance information at the time of service. If the insurance card(s) is not presented at the time of service, the charges are your responsibility until a copy of the insurance card(s) is received. In order for services to be billed to your insurance company, a copy of the insurance card(s) must be received within 10 days from the date of service.

____Initial **Co-Payments, co-insurance and all outstanding balances** are expected to be paid at the time of service unless previous arrangements have been made, even if you have not received a bill. Credit card information will be kept on file for all recurrent services and deductibles.

____Initial **Referrals:** If your plan requires referrals for specialty care, **it is your responsibility to obtain a referral from your primary care physician.** If a referral is not obtained, your appointment may be canceled, or you will be responsible for all charges.

____Initial **No Shows**: A $35 no show fee will be assessed for all visits not previously canceled.

____Initial **Late Arrivals:** Any patient arriving later than 15 minutes, the appointment may be rescheduled.

Authorization for Treatment and Release of Information.

____Initial I_____ authorize Naugatuck Valley Ear, Nose and Throat Associates to contact me by telephone with medical information pertaining to my child(ren)'s or my care. If I am unavailable, this authorization gives Naugatuck Valley Ear, Nose, and Throat Associates permission to leave this information either on my answering machine or with a member of my household.

____Initial I authorize Naugatuck Valley Ear, Nose and Throat Associates or whomever they designate to evaluate and treat my above-named child and to release to my insurance company any information acquired in the course of my child's examination or treatment, and to receive all payments for such examination or treatment. NVENTA has my permission to release any diagnostic studies, reports, etc., to a specialist involved in caring for my child.

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Patient Signature **Date**