

BEACHES EAR, NOSE AND THROAT, PA

OFFICE POLICIES

In order to complete the registration process, please read and sign the following policies:

1. I authorize this office to release or receive any information necessary to expedite insurance claims payment.
2. **I understand that all co-payments for office visits are collected prior to the visit.**
3. I hereby authorize this office to bill my insurance company directly for their services.
4. I authorize payment directly to this Clinician of any insurance benefits otherwise payable to me.
5. In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to my Clinician for which these fees are payable.
6. I understand that I am directly and fully financially responsible to this Clinician for charges not covered by my insurance.
7. I understand that there is a \$35 charge for all returned checks.
8. I hereby consent to participate and receive treatment by Jeffrey E. Brink, MD, Stephanie M. Collins, PA-C, and/or Nicole Wyzinski, Au.D., CCC-A.
9. I affirm that I am of legal age and otherwise competent to consent to treatment. If not, the person signing below represents that such person as the parent/legal guardian or a person otherwise allowed by law to consent to the treatment of the patient and by their signature hereto consent.
10. I understand that there is a 24-hour cancellation policy and that if 24-hour advance notice is not provided, I agree to be billed and pay \$50.
11. I understand that in the event copies of records, a letter from the doctor or completion of forms is necessary, there will be a processing fee for these services. In addition, it is this office's policy to collect pre-payment for these services. Fees vary, depending on specified needs. Please allow 7 days for completion of disability forms.
12. I understand that prescription refills can take up to 72 hours to be called in to the pharmacy. Please request these in advance to avoid problems.
13. No narcotic pain medicine will be called in after regular office hours.
14. **I understand that I will be responsible for any and all charges incurred from a collection agency should my account be turned over to them.**
15. **I understand that there is a 72-hour cancellation policy for surgical procedures, and that if 72-hours advance notice is not provided, I agree to be billed and pay \$100.**

I understand and accept the policies states above:

Signature

Date