Cabarrus Ear, Nose, Throat & Facial Plastic Surgery Center
Financial Policy

- We will file your insurance for you. All copayments, deductibles, and coinsurance are collected at the time of service. If you do not have your copayment with you at your appointment, you may be asked to reschedule.

- If your insurance requires a referral for a specialist, it is the patient's responsibility to make sure this has been completed by the primary care physician.

- In the event that your insurance plan determines a service as "non-covered", you will be responsible for the charge. Please advise our insurance department with any "special riders" or limitations that your policy may have.

- The responsibility for payment of services to any dependent children whose parents are legally separated or divorced, rests with the parent who seeks treatment.

Surgery Cancellation Fee:

- The patient must notify our office **at least five business days prior to the surgery date**. This allows us to offer these surgery appointments to other patients. **Failure to notify the office will result in a $200.00 non-refundable cancellation fee.**

- **When canceling an in office procedure, the patient must give our office at least 48 hours notice prior to the appointment to avoid a $75.00 cancellation fee.**

Billing Statements:

- The patient will have 90 days or three billing cycles to pay any remaining balances after the insurance has paid. The patient will receive only three statements. After the third statement is mailed, and the balance has not yet been paid, the account will be turned over to an outside collection agency. This will impact your credit rating. A 33% late fee will be added to your account if the balance is not paid within the 90 day period. Our office only keeps balances "in house" for 90 days unless payment arrangements have been made.

ASSIGNMENT OF INSURANCE BENEFITS: I HEREBY AUTHORIZE PAYMENT TO ROBERT C. JARCHOW, M.D/CABARRUS ENT & FACIAL PLASTIC SURGERY CENTER. I am financially responsible to ROBERT C. JARCHOW, MD/CABARRUS ENT & FACIAL PLASTIC SURGERY for charges not covered by this authorization.

Insured's Signature _____ Date _____