Spartanburg&GreerENT

Patient Name _____ Account # _____

FINANCIAL POLICY OF SPARTANBURG & GREER EAR, NOSE & THROAT

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with correct information to bill your insurance.

2. If you have a change of address, telephone number, or employer, please notify the receptionist.

3. Deductibles, co-payments or charges for non-covered services are due at the time of service. We accept cash, checks, major credit cards and Care Credit.
There will be a $30.00 fee for all returned checks.

4. You are expected to provide payment for previous balances or balances sent to collections prior to your office visit. If you are unable to pay your balance in full, contact our billing department at (864) 699-6981. We reserve the right to refuse service.

5. SELF-PAY PATIENTS: Patients with no insurance are expected to pay at time of service. A discount is offered for payment in full at time of service. If you can't pay in full, contact our billing department prior to seeing the doctor to make payment arrangements.

6. No show or missed appointments – When an appointment is scheduled with the doctor, time is specially allocated for you. Unable to keep an appointment, we ask the courtesy of a phone call to cancel your appointment. We prefer a 24 hour notice of cancellation.
Not keeping an appointment may incur a $50.00 fee.

Remember, whether you do or do not have insurance, you are ultimately responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing department at (864) 699-6981.

I have read and have a full understanding of the financial policy of Spartanburg & Greer ENT.

Signature: _____ Date: _____

(required age 18 & older)