THE CENTERS FOR ADVANCED
ENT CARE
MONTGOMERY
OTOLARYNGOLOGY DIVISION

LINDSAY I. GOLDEN, MD., F.A.C.S
MICHAEL H. ARENSTEIN, MD., F.A.C.S
CHRISTOPHER K. SINHA, MD., F.A.C.S

Our Office Policies

REFERRAL POLICY
Patients whose insurance requires a referral or treatment plan must have a valid and current referral or treatment plan from their primary care doctor in order to be seen. Your appointment will be rescheduled if the proper electronic or paper referral is not present. If you choose to be seen without obtaining the proper referral, you must sign an insurance waiver and payment in full is expected at the time of your visit.

MISSED APPOINTMENTS POLICY
There is a $50.00 charge for missed appointments, unless you have called to cancel at least 24 hours prior to your appointment. This fee must be paid prior to your next visit.

RESCHEDULING SURGERY POLICY
There is a $250.00 fee for rescheduling or canceling of surgery if we are not informed 5 business days before the scheduled procedure.

ADDITIONAL FEES
The following fees also apply:

Completion of forms required by employers or insurance companies: $10- $25 depending on length of forms.

Copying of medical records: **$18.16 handling fee plus $0.60 cents per page**

COLLECTION FEES: **If for some reason you fail to pay your account balance in a timely manner and the balance is subsequently sent to our collections agency then YOU WILL BE RESPONSIBLE FOR THE COLLECTION FEES AND ANY OTHER LEGAL FEES ASSOCIATED WITH THE COLLECTION PROCESS.**

By signing below, you are indicating that you have read and understand the policies as they are written above:

_____ _____
Signature of Patient or Guardian Date

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Additional Patient /Guardian Authorizations

I authorize Montgomery Otolaryngology, a Division of The Centers for Advanced ENT Care, LLC, to apply for benefits on my behalf for services rendered by them. I request payment from my insurance company be made directly to Montgomery Otolaryngology. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

Signature of Subscriber or Guardian _____

Date _____

I authorize the physicians and staff of Montgomery Otolaryngology to contact me or those listed under my Emergency Contact(s) to discuss **privileged health information** as follows:

Home phone -	YES	NO	Leave message	YES	NO
Cell phone -	YES	NO	Leave message	YES	NO
Work phone -	YES	NO	Leave message	YES	NO
Email -	YES	NO			

Signature of Subscriber or Guardian _____

Date _____

I authorize Montgomery Otolaryngology to release the required personal information in order to obtain the necessary reports and medical information to ensure accurate information is available for my care. In addition, I give permission for them to access an electronic database that will provide information regarding prescription medications that have been prescribed and filled for me at those pharmacies that provide that information to the database through my pharmacy benefit insurance plan.

Signature of Subscriber or Guardian _____

Date _____