Jonathan Wiggenhorn, DO
Board Certified in Otolaryngology-Head and Neck Surgery
Simran Kaur, NP-C
Nurse Practioner

Estrella Ear, Nose & Throat Financial Policy

Thank you for choosing Estrella Ear, Nose & Throat. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered, allowing us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our billing department will be glad to discuss these policies with you.

1. ____ I understand that if I do not have my insurance card, referral and/or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments. I further understand that for a deductible of $250 or more, I will be asked to fill out a credit card authorization form in order to process payment once your claim has been posted to your insurance company and the office visit has been applied to your deductible.
2. ____ I understand that if my account is not paid in full, my account will be turned over to a third-party collections company for further processing and I will be responsible for paying any collection fee incurred by the practice. Any such fees will be added to the outstanding balance owed. No additional appointments will be made for delinquent accounts until they are brought current.
3. ____ I understand that if I am unable to make a scheduled appointment I need to contact Estrella Ear, Nose & Throat at least ***24 hours*** before my scheduled appointment time. ***An automated reminder call will be made on your behalf and it is necessary that you provide us with a primary phone number from which you check your messages regularly.*** Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent appointments from being seen. A $50 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENT NOT CANCELLED WITH AT LEAST 24-HOUR ADVANCED NOTICE. If a patient misses 2 visits, Estrella Ear, Nose & Throat reserves the right to discontinue the provider-patient relationship. A letter will be sent to the patient notifying you of such a change.
4. ____ **It is my responsibility to provide correct insurance information and notify Estrella Ear, Nose & Throat if there is a change in my insurance coverage, residence, or phone number. It is also my responsibility to provide my insurance company with any information that may be requested by them in order to process a claim for services.** If a claim is denied by insurance because I did not provide the correct insurance information or respond to any information requests in a timely manner, I understand that I will be financially responsible for any and all treatment(s) received. **ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.**
5. ____ I have read and I understand the above Financial Policy and I agree to abide by its terms.

_____ _____ _____

Printed Name of Patient Signature of Patient/Responsible Person Date

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www.estrellaent.com