

**EASTERN CONNECTICUT EAR, NOSE & THROAT, P.C.**  
**Office and Financial Policy Agreement**

Thank you for choosing Eastern Connecticut Ear, Nose & Throat, P.C. (ECENT) for your medical care. A copy of this policy is available on our website or by request at the office.

**PLEASE READ ALL INFORMATION AND ACKNOWLEDGE YOUR UNDERSTANDING BY SIGNING BELOW.**

1. Please arrive on time for your appointment. If you arrive 15 minutes late, you may be asked to reschedule. A fee of \$50.00 will be charged for no show appointments. Chronic no show appointments may result in the termination of physician/patient relationship. Please make every effort to notify the office 24 hours in advance if you wish to cancel or reschedule an appointment.
2. Please bring a current photo identification and insurance card to your visit. It is your responsibility to provide us with the correct information to bill your insurance and a photo ID helps to protect your identity. Please inform the receptionist of change of address, phone, employer or other pertinent information.
3. Co-payments, non-covered procedure charges and back balances are due at the time of check in. We accept cash, checks and credit cards. Financing options are available with prior approval. A \$25.00 returned check fee will be charged to your patient account on all returned checks.
4. In-office diagnostic procedures are not included in the standard office visit charges. These procedures are billed separately and in addition to office visit charges. Some insurance companies will pay all, part, or none of the cost of this procedure. Any charges not covered by your insurance are your responsibility.
5. If you have a balance after your insurance makes payment, you will be expected to pay your balance within 30 days of billing or call our billing department to make payment arrangements. If you do not pay in a timely manner, your account may be referred to a collection agency and reported to the Credit Bureau. Patients with uncollected balances will be dismissed from the practice. All costs associated with our use of a collection agency will be added to your patient balance.
6. You are responsible for providing us with a referral from your primary care physician prior to your visit, if required by your insurance. You are responsible for understanding the coverage and limitations of your health insurance plan. We encourage you to contact member services for detailed insurance benefit information. Since the insurance contract is between the insured and the carrier, ECENT cannot be held responsible for the limitations of your coverage.
7. Workers' Compensation visits must have authorization from an adjustor or case manager prior to the visit. You are responsible for providing us with this information along with all pertinent information needed to file the claim.
8. The responsibility for payment of services rendered to dependent children whose parents are separated or divorced lies with the person bringing the patient to the doctor. Minors must be accompanied by a parent or legal guardian or have written permission from the parent, legal guardian or court.
9. Surgical procedure charges will be discussed prior to surgery and any co-payments, deductibles or non-covered charges must be paid or have pre-approved payment arrangements made prior to surgery.

I have read and understand the Office and Financial Policy.

\_\_\_\_\_  
Patient name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

36 Watson Street, Willimantic, CT 06226 - 860-456-0287  
79 Wawecus Street, Norwich, CT 06360 - 806-886-6610  
914 Hartford Turnpike, Waterford, CT 06385 - 860-537-1903  
Fax: 860-456-3532 Referral Fax: 860-456-8382

[www.easternctent.com](http://www.easternctent.com)