# OAKLAND ENT

6900 Orchard Lake Road, #314, West Bloomfield, MI 48322 (248) 855-7530 Fax (248) 855-5639
4600 Investment Drive, #170, Troy, MI 48098 (248) 267-5004 Fax (248) 267-5007

## Office Billing Policy:

(This form requires a signature)

**Insurance copays will be collected on the date of service. If you are not able to pay your copayment today, please reschedule your appointment. For your convenience, our office accept checks, Visa, Mastercard, Discover, American Express and cash.**

**There will be a $5.00 per month statement fee that will be charged to your account each month if our office has to mail a statement to collect for an office copay.**

It's our office policy to verify eligibility for ALL insurances on the date of service. If we determine your policy is in the "grace period," you will be informed and have the option to reschedule your appointment. Our office reserves the right to collect IN FULL for services rendered on the date of service and thereafter, if there's a lapse in coverage and/or termination of the plan.

**We reserve the right to collect ANY and ALL balances IN FULL on the date of service, prior to being seen.**

Private pay (no-insurance) must pay IN FULL on the date of service, prior to being seen.

Our returned check fee is $35.00. In addition, there will be a $5.00 statement fee.

****There is a $50.00 charge for ALL scheduled appointments that you DO NOT show for.**

**We require 24 hour notice for cancelled and/or rescheduled appointments. The office reserves the right to refuse rescheduling future appointments after several cancelled and/or rescheduled appointments.**

If after 90 days, we have not received payment from your insurance company, our office reserves the right to send the entire bill to the patient for payment. It will be your responsibility at that point to contact your insurance company with any questions or concerns regarding your bill.

Due to many changes to insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay on top of these changes, it is not always possible. **It is your responsibility to know the special terms, deductibles and/or copays of your insurance coverage.** Failure to notify us will result in non-covered expenses which will be your responsibility.

If your insurance (HMO) requires you to have a written referral, it is the responsibility of the patient to obtain PRIOR to the appointment. If you do not have the referral, you will need to reschedule your appointment.

Please remember your insurance policy is between you and your insurance company and not with the insurance company and your doctor.

The intention of this notice is to clarify our office policies and procedures and promote good communication between our patients and our office.

I understand the billing procedures associated with this office and completely understand additional charges will be incurred if I fail to comply. I agree to pay ANY balance IN FULL as set forth by my insurance company and/or charges set forth by this office.

_____ _____

Print patient name Signature of patient and/or guardian if under 18 yrs old

_____ _____

Relationship to patient Date of signature