Philip A. Scolaro, M.D.
David W. Cuthbertson, M.D.
Otolaryngology
Head and Neck Surgery

EAR NOSE & THROAT
ASSOCIATES OF LUBBOCK

Cathy M. Thackrey, Au.D., CCC-A
Audiology
Hearing Aids

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I hereby authorize Ear, Nose & Throat Associates of Lubbock to release information requested by my insurance carrier, or any person, company or agency responsible for processing claims for my medical services. I also authorize assignment of all payments for medical services performed by this provider to be paid directly to Ear, Nose & Throat Associates of Lubbock.

I acknowledge that I am fully responsible for providing current insurance information, obtaining PCP referrals (if required by my plan), and updating any changes in coverage with this office in a timely manner. I acknowledge that I am fully responsible for charges not paid by my insurance or other agency including, but not limited to: copays, deductibles, coinsurance, balances resulting from failure to provide updated insurance information and/or lack of a PCP referral.

I acknowledge that payment is due at the time services are rendered, including collection of all copays, deductibles and coinsurance. I understand that some services rendered in a specialist's office (i.e. audio testing, scopes, minor surgical procedures, etc.) may be subject to deductible and/or coinsurance in addition to office visit copays. I understand that Ear, Nose & Throat Associates of Lubbock will verify my insurance benefits prior to my appointment and will make a good faith effort to collect based upon the information provided by my insurance company. This information may not reflect the finalized claim patient responsibility determined by my insurance plan.

I acknowledge the following fees: a **$25 fee for returned checks**, a **$35 fee for office appointments not cancelled within 24 business hours of appointment time and same day cancellations and a $250 cancellation fee for surgeries not cancelled or rescheduled within three (3) business days of the scheduled procedure (unless cancelled by the surgeon).** I understand that this office closes at noon on Fridays, so Monday afternoon appointments must be notified before close of business on Friday to avoid a cancellation fee. For surgeries, I understand that I must notify this office directly and not the surgery center or facility where the procedure is scheduled. I agree to be considerate when cancelling or rescheduling a surgery or appointment so that Ear, Nose and Throat Associates has enough time to accommodate other patients.

Ear, Nose & Throat Associates accepts cash, checks, credit/debit cards and CareCredit. I understand that it is my responsibility to manage, maintain and track any payment plans that have been put in place with this office. I acknowledge that my account may be referred to a collection agency for unpaid balances after reasonable attempts to collect the balance have been exhausted.

By signing below, I acknowledge receipt of, and agreement to this practice's patient financial responsibility.

_____ _____

Printed Patient Name Date

_____ _____

Signature of Patient/Guarantor Printed Guarantor Name (if different from patient)