Philomena Behar, MD
Lucille Kingston, PNP
Chelsea Cantie, PA
Jessica Stengel, PA

Your child has an upcoming appointment with our office on _____ at _____. Please complete the enclosed forms prior to your appointment and bring them to the appointment.

Your appointment is at: 3580 Sheridan Drive, Suite 120
Amherst, NY 14226

A parent or legal guardian must accompany all patients under the age 18 for the first appointment. (A letter from the parent to another adult cannot be accepted.)

Payment Methods:
Our office accepts cash, personal checks, Master Card, Visa, and Discover cards. There is a service charge of $25.00 for returned checks.

Participating Insurance Plans:
We participate with the following insurance companies. This means we bill your insurance company and receive payment directly from them. You will only be billed for those balances that are your responsibility as per your contract.

Aetna
BC/BS
BC/BS Child Health Plus
Empire Plan
CIGNA
Community Blue
Community Care
Fidelis
GHI/Emblem Health
Independent Health
Independent Health
Medisource
Medicaid (New York only)
Medicare
Molina
Nova
Pomco
Tricare
Univera

Non-participating Insurance Plans:
We are happy to see patients of non-participating plans. We will help submit your bill to the insurance plan and you will directly receive reimbursement from them. We ask you to pay your charges at the time of the visit.

Referrals:
After you have made your appointment, please call your child's primary care physician, they will obtain a referral from your insurance. This referral must be in place prior to your child's appointment. We are unable to see your child without this referral. There are also some self-funded Independent Health contracts that require a referral, please check your insurance plan.

Financial Responsibility:
Co-payments— Some insurance companies require us to collect a co-payment at the time of your office visit. This may or may not be stated on your insurance card. We will call your insurance company prior to your appointment to verify your co-payment.

Filling Out Forms:
There is a $10.00 fee for any form that needs to be completed by our practice. This fee must be paid prior to the forms being filled out. (example: FMLA forms)

Co-insurances and Deductibles:
Prior to your office visit or surgery our office will contact your insurance to determine whether there are any co-insurances and deductibles that will apply to your visit. These must be paid at the time of the visit. We then submit a claim to your insurance to ensure that these charges are applied toward your deductible.
High Deductible Plans (Health Savings Accounts or Health Reimbursement Accounts)

If your insurance is a High Deductible Plan you will be required to pay a $150.00 deposit prior to your visit. If the total cost of services rendered is more than $150.00 you will be billed for the remaining amount.

No Insurance:
Payment is required at the time of service, if there is no insurance coverage at the time of the visit. For those families with special financial needs, we will try to work closely with you to assure that your child can still receive medical care.

Rescheduling Appointments:
If you need to reschedule your child's appointment, we ask that you give us 24 hour notice. This will allow us to fill that appointment slot with another patient that is waiting to be seen. If you fail to keep your appointment or if you cancel your appointment with less than 24 hours notice, there will be a $60.00 charge applied to your account.

Surgery:
If you proceed with your physician's recommendation for surgery, a pre-surgical deposit may be required. Some insurance plans have a deductible and/or co-insurance. We will estimate and discuss with you any amounts due prior to surgery, based on your insurance benefits and coverage. **All surgical deposits must be paid 2 business days prior to the date of surgery.** If you have any questions or concerns, please contact our Billing Office @ 362-9730 Ext. 603.

PLEASE NOTE: OUR CHARGES ARE FOR OUR SERVICES ONLY AND DO NOT INCLUDE ANY HOSPITAL, LABORATORY, ANESTHESIA OR OTHER ANCILLARY CHARGES THAT MAY BE RELATED TO YOUR SURGICAL PROCEDURE.

If you cancel surgery with less than 24 hours notice, there will be a $100.00 charge applied to your account.

Pre-Authorizations:

1) CT& MRI may require Health Insurance preapproval. Our office will assist in this process that may take 7-10 business days and we may need your assistance.
2) Medications may also require Insurance approval. Again, this may take 7-10 days.

Late Fees
Patient balances are due within 30 days from the date of the initial statement. A $15.00 late fee will be assessed on each patient statement generated after the first statement until the outstanding balance is paid. Please contact our billing department if you are unable to pay your balance and we can arrange a payment plan.

Coverage for In-Office Procedures:
Please note that some insurance companies may not pay fully for some in-office procedures such as: hearing exams, wax removal, voice box exam (endoscopy), etc.. Please check with your insurance company prior to your visit.

Guarantor Signature:
I request the payment of authorized Insurance, Medicaid and Medicare benefits be made on my child's behalf to Pediatric ENT Associates, PLLC. I authorize any holder of medical information about my child to release to the Centers of Medicare and Medicaid Services(CMS) and its agents or my insurance company any information needed to determine the benefits payable. I further agree to make payment for any and all services not paid by my health insurance plan.

_____

Patient Name **Account #**

X_____

Signature of Guarantor **Relationship** **Date**

Please note: There may be changes made to the policy without notice. If you would like a current copy of the policy, please contact our office.

Revised 12/11/15