MORELAND
EAR, NOSE & THROAT

Financial Policy

Copay Policy
Copayments are due and will be collected at the time of your visit.

Payment Plan Policy
We are committed to delivering safe, high-quality care cost-effectively. As part of our commitment to help you and your family with these bills, we offer an online payment option that allows you to pay the bill in full. Payment on unpaid balances is expected within 30 days of your first statement. Any missed payments on a payment plan must be paid in full to be considered in good standing.

Our Payment Plan Agreement option is a flexible and affordable way to pay the costs of your procedure. It includes:

- Zero interest and an APR of 0% for the life of the plan
- Monthly payments you can make online, or you can choose to schedule recurring payments from your bank account or credit card for your convenience
- Ability to select a preferred payment day of the month
- No fee for early payoff
- A cash down payment may be required at the time you sign a Payment Plan Agreement

Payment Plan Agreement Terms

Balance	Payment Terms
Less than $600	$50 per month, up to 12 months
$600–$1,200	$100 per month, up to 12 months
Greater than $1,200	Total amount divided by 12 = monthly payment amount

Audiology Services Payment Plan Requirements
Payments of non-covered services follow the above payment program; however, to be eligible for platinum care supplies, drop-off services and/or service plan visits, the account must be in good standing. Those patients who fail to meet the designated requirements of their payment plan or who maintain outstanding balances in default status are not eligible to receive these services until the account is in good standing. An account in good standing may require payment of multiple missed payments to satisfy the current agreement.

Right to Revoke Authorization
I request that payment of authorized medical benefits be made on my behalf directly to the Moreland ENT provider of service(s) furnished to me. I authorize Moreland ENT to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private group employer's or group health insurance plan, directly to Moreland ENT. I hereby authorize that any photocopies of this form shall be as valid as the original.

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Patient Signature or Personal Representative *Date*

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Patient Name