PHYSICIANS HEARING & BALANCE CENTER
DR. ROBERT L. BORENITSCH, D.O.

Date: _____ Patient Name: _____

Birth Date: ____/____/____ Patient Address: _____

Sex: ○M ⊙F (circle one) City: _____, Zip _____

Phone: ( ) _____ Marital Status: ○S ⊙M ○W ○D (circle one)

Work ( ) _____ Cell Phone ( ) _____

Patient Medical Insurance Carrier: _____

Name of Insurance Contract Holder: _____

Birth Date & Social Security of Contract Holder: ____/____/____, _____

Family Doctor: _____
Name and Phone Number of Nearest Relative not living with you:

_____ ( ) _____

Minor child mothers' name_____ Minor child fathers' name_____

Our Financial Policy

Thank you for choosing Dr. Robert L. Borenitsch as your healthcare provider. We are committed to your treatment being successful. Our Billing Department will work very hard to make sure your paperwork is filed accurately and promptly. In order to provide you with the highest quality service while keeping our billing costs low, we accept all major credit cards, debit cards, check cards, checks and cash.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates.

Thank you for your understanding of our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree with the Financial Policy.

_____

Signature of patient or responsible party **Date**

_____

Printed Name of responsible party

Insurance & Insurance Collections

We may bill your insurance carrier as a courtesy. In the event that your insurance does not reimburse us within 45 days, we will simply transfer the balance over to patient responsibility.

All co-payments must be satisfied each and every visit. There can be no exceptions due to the contracting and uniform compliance rules. You are responsible for getting proper referral information in advance of your appointment.

As a participating provider, we will bill your Medicare carrier. We can bill your co-payments to your secondary carrier if the information is provided by patients.

Having more than one insurance carrier **does not** necessarily mean that your services are covered at 100%. We may bill your second carrier as a courtesy. You are responsible for any balances after your insurance (s) have cleared.

Divorce Decree
This office is not a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying parent.

Service Charge
Billing statements are sent out on a monthly basis. If payment is not received within thirty days, a $5.00 service charge will be added to your account balance.