ROCKY MOUNTAIN EAR, NOSE & THROAT
1501 WEST MINERAL AVEUNE, SUITE 270
LITTLETON, CO 80120
303-795-5587

OFFICE POLICYRocky Mountain ENT strives to provide our patients with the best care possible. In doing so, we will need you to provide our office with complete and accurate insurance information at the time of service in order to file insurance claims on your behalf. The following is a statement of our office policy; **we require you to read, agree to, and sign to any non-emergent treatment.**

All patients must complete our **Patient Information Form** prior to being seen by our physicians. This form must be updated every six months if you have moved, or changed insurance companies. If you have new insurance you must provide our office with a copy of your new insurance card.

It is the patients responsibility to provide current insurance info oration. If you do not bring your **Insurance card or information** to your appointment, you will be expected to pay for services upon check out. You may also, have the option to reschedule.

Referrals: If your insurance plan requires a referral from your **Primary Care Physician**, it is your responsibility to insure that the referral is current and our office has received the **referral prior to your appointment**. In the event our office does not either have a referral or a current referral you may choose to either reschedule your appointment or pay for the services in full upon check out.

Co-Payments: Co-Payments must be made upon check-in. Our office accepts Cash, Check, Master Card and Visa. Please note for all checks there will be a $25.00 returned fee plus bank charges.

No Insurance: Payment is due at the time of service.

Endoscopy/Laryngoscopy: In the event that your condition requires an endoscopy/laryngoscopy, a fiber optic scope may be utilized in office to further evaluate and treat your condition. Please be aware that the American Medical Association notes that this is a surgical procedure. **You may be responsible for any charges that exceed the maximum allowable amount your insurance will pay for this exam.**

I have read and fully understand, and agree to all terms set forth in the above Office Policy.

_____ Responsible Party (Please Print Name)

_____Sign and Date

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