

Capital Region Center for Special Surgery
Capital Region Neurosurgery
Capital Region Ear, Nose & Throat
The Ear Institute

Patient Name _____ Date of Birth _____

We appreciate the confidence you have shown in choosing us to provide for your health care needs.

You are responsible to provide us with correct insurance information at the time you are seen. If you fail to do so or provide us with incorrect information you will be responsible for any charges that are not paid.

You are also responsible for any co-pay, co-insurance or deductibles required by your insurance company. You are responsible to know how much your co-pay is and pay at the time service is rendered. You are also required to obtain a referral from your primary care physician if your insurance requires one. Failure to collect the co-pay at the time of service does not mean you do not have one. You will receive a bill for any services deemed by insurance contract to be the patient responsibility.

If a referral is required and you do not have one at the time of service you will be financially responsible for the services you receive.

There may be services that are not covered under your particular insurance contract. If you elect to have these services you will be responsible for the fees incurred. Depending on the procedure planned you may have to pay a percentage of the cost up-front.

I have read the above policy regarding my financial responsibility for services provided to me or the above named patient. I certify that the insurance information is to the best of my knowledge true and accurate.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____

(If guarantor is not the patient)