advanced
EAR, NOSE & THROAT
head and neck surgery

Randall S. Lomax D.O.

Financial Policy

Dear patient,

Thank you for choosing us as your healthcare provider, the following is our office financial policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies please do not hesitate to ask.

We ask that all patients read and sign our financial policy and fill out the patient information form prior to seeing the doctor.

Cash patients please remember that payment for services is due at the time services are rendered. Our office may offer you a cash discount and a payment plan if necessary.

For your convenience we accept Cash, Check, MasterCard, Visa, Discover Card or American Express.

All copays and deductibles are due at the time of service. If your financial responsibly is not paid, a $25.00 charge will be added to your bill. Please initial _____.

If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help process your outstanding claim(s). Please remember that your insurance requires us to collect all co-pays and deductibles prior to services being rendered. This is our contract obligation and your obligation to your insurance company.

All insured patients are required to sign the assignment of benefits for payment from the insurance company.

All returned checks will be subject to a $35.00 NSF fee.

Delinquent accounts will be turned over to an attorney and/or collection agency without notice. All accounts will be considered delinquent if unpaid after 90 days. In the event your account is turned over to a collection agency you will be responsible for collection agency and court costs up to 50% of the outstanding balance at the time the account is considered delinquent.

Again, we thank you for choosing us as your healthcare provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Patient signature: _____ Date: _____

Assignment of benefits

I hereby guarantee the payment of all charges incurred at the office of Dr Randall S. Lomax DO. I hereby assign and direct to pay any and all benefits for medical services under this claim directly to Randall S. Lomax DO, PLLC. I hereby authorize the release of any medical information requested by the insurance companies with the above assignment.

Patient signature: _____ Date:_____