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5378 Avery Road
Dublin, Ohio 43016

Managed Care Insurance

Ohio Sinus Institute will submit insurance claims for medical/surgical services provided to patients with insurance coverage in a managed care plan (PPO, HMO, POS) that our office participates in. A copy of your insurance card must be presented to our office. Patients without an insurance card must pay at the time of service. Patients presenting valid cards with PPO, HMO and POS identification are required to pay their co-pay amount, if applicable, at the time of service. Managed care discounts will not be honored if the insurance card provided at the time of service does not indicate a plan that our office participates in. For patients in participating plans, charges for services rendered will be sent to your insurance company for direct reimbursement to our office. You will receive a statement if a balance representing your portion owed remains due after we receive payment from your insurance company. If you participate in an HMO or POS plan that requires authorization from your primary care physician, we require a referral or authorization number at the time of service in order to submit your insurance claim for payment. Without a referral or authorization from your primary care physician, your benefits may be reduced or denied entirely. HMO patients without referrals incurring medical services or seeking out-of-network services will be required to pay at the time of service.

Medicare and Medicaid Insurance

Ohio Sinus Institute accepts Medicare and Medicaid assignment. Copies of current Medicare and Medicaid cards are required. Medicaid cards with invalid dates will not be accepted and patient will be required to pay at the time of service. Our office will submit claims to Medicare, the Illinois Department of Public Aid and participating Medicare supplemental plans for reimbursement. Insurance payment will be issued to Ohio Sinus Institute. If a balance representing your co-insurance, deductible, or non-covered portion remains due after insurance payment is received, you will receive a statement indicating your portion owed. A 15% discount will be honored for non-covered services that are paid in full at the time of service.

Traditional Indemnity Insurance

For Patients with traditional indemnity coverage, our office will submit a claim to your insurance company for direct reimbursement to Ohio Sinus Institute. If a balance remains due after insurance payment is received, you will receive a statement indicating your portion owed.

Self-Pay

Patients without medical insurance are requested to pay at the time of service. If you cannot pay for medical services in full, you may consult with a member of our business office staff to arrange a payment plan. Payment plans remain an option for all patients regardless of insurance coverage. I understand the provisions of Ohio Sinus Institute's Billing Policy as they apply to me. I further understand that I am financially responsible for any charges not covered by my insurance plan and that full payment is due within 90 days of the date of the service(s). I understand that if my balance exceeds 90 days, credit and collection procedures will commence and a monthly interest charge at the rate of 1% of the outstanding balance will accrue on my account unless special financial arrangements are made in advance with the office staff.

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Date Patient Name Signature of Patient/Responsible Party

Assignment of Benefits and Records Release Form

Release of Records:

I hereby authorize Ohio Sinus Institute to provide diagnostic and treatment services to me. Ohio Sinus Institute has my permission to release any information needed for completion of their claims for payment from third party payers, including but not limited to: insurance companies, health maintenance organizations government agencies and their representatives. I permit release of information concerning dates of treatment, condition, diagnosis, procedures or surgeries to my personal physician, referring physician, and/or the referring facility or for follow-up care. I am aware that this authorization to release information may include information regarding HIV or AIDS, alcohol or drug abuse, and/or psychiatric treatment.

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Date Patient Name Signature of Patient/Responsible Party

Assignments of Benefits:

I acknowledge financial responsibility for all facility and physician(s) fees. I understand that the physician billing office will file my insurance claim if my physician/provider is a participating provider with my insurance carrier and I assign direct payment to the physician all payments made under the terms and provisions of my policy. I further understand that any disputes on coverage are between my insurance carrier and myself and I will be responsible for payment for denied services regardless of the outcome of my dispute. I understand that I am responsible for and will pay my portion of the unpaid balance due for services performed by the facility and physician/provider.

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Date Patient Name Signature of Patient/Responsible Party

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Authorization for Medicare Patients Only

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Ohio Sinus Institute for any services unfurnished to me by that physician. I authorize release to the Health Care Financing Administration and its agents any medical information about me to determine the payments for related services.

In Medicare assigned cases the physician agrees to accept the charge determination of the Medicare carrier as the full charge. I am responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and deductibles are based upon charge determination of the Medicare carrier.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 on HCFA-1500 claim form is completed, my signature authorizes release of the information to the insurer of agency shown.

This authorization is in effect for my lifetime or until I choose to revoke it.

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Date Signature of Medicare Beneficiary

Acknowledgement of Receipt of Privacy

Your privacy is important to us. We create information about you so we may provide you with quality care. We are committed to protecting this information. The Notice of Privacy Practices describes your rights with regard to your health information. This is a summary of the more detailed information contained in out Notice of Privacy Practices.

Your rights include:

- A right to inspect and copy your medical information
- A right to amend your health information
- A right to request restrictions on what information we use or how we disclose your health information
- A right to receive an accounting of certain disclosures we have made of your health information
- A right to receive a paper copy of our Notice of Privacy Practices

These rights do have special restrictions, so it is important that you read the full Notice.

We may use your health information and/or records to:

- Plan for your care
- Help your health care providers communicate and work together to care for you
- Submit bills to pay for your care
- Help health care payers make sure services were actually provided
- Help improve the quality of health care. For example, after your visit we may contact you to see how you are doing and find out how you felt about our service
- Disclose information to certain officials or organizations where we may, or are required to do so by law

I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, and why my confidential health information may be used or shared. I acknowledge that Ohio Sinus Institute physicians and other Ohio Sinus Institute staff may use and share my confidential health information with others in order to arrange for payment of my bill and for issues that concern Ohio Sinus Institute operations and responsibilities.

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Date Patient Name Signature of Patient/Responsible Party

Signature of staff member delivering notice: _____

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Attempt to Deliver Notice of Privacy Practices:

_____

Patient Name Date

However, delivery could not be made because:

_____

_____

Signature of Practice Employee Title Date