Financial Policy and Responsibility

In order to ensure insurance benefit coverage for any services rendered, it is imperative that the patient provide a current insurance card at each office visit. If insurance verification and coverage cannot be determined prior to the visit, payment will be requested at the time of service. Please be advised that the eligibility and benefit information supplied by your insurance company is only an estimate and is not a guarantee of payment by the insurer. Actual benefits are subject to all plan terms, definitions, limitations and exclusions in effect on the date of service. **Ayala ENT & Facial Plastic Surgery and Ayala Nasal Sinus Institute/Ayala Plastic Surgery Institute** will submit your claim/bill to your insurance company for services performed by our Medical providers or at our medical facilities; however, it is ultimately the patient's responsibility to pay for any and all services provided.

If the patient's insurance plan requires a referral from the patient's primary care physician (PCP), it is the patient's responsibility to secure the referral. In addition, please be aware that not all medical facilities participate in each patient's insurance policy; therefore, the patient should verify facilities participation with their insurance prior to scheduling diagnostic, ancillary or specialty care conducted outside of **Ayala ENT & Facial Plastic Surgery and Ayala Nasal Sinus Institute/Ayala Plastic Surgery Institute.**

Ayala ENT & Facial Plastic Surgery and Ayala Nasal Sinus Institute/Ayala Plastic Surgery Institute, is not responsible for verifying benefits for hospitals, anesthesia or any other outside ancillary services or facilities.

Co-payments and deductibles are due at time of service. For your convenience, payments can be made via cash, money order, Visa, MasterCard, Discover or American Express. When necessary, our business office is happy to assist patients in making special payment arrangements for unexpected and emergency services.

State law requires that insurance companies pay most claims within 45 days of submission. If there is difficulty processing any claim(s) submitted, we may ask for your assistance working with your health care plan provider. It is very important that you respond promptly to any inquiries from your insurance company since failing to do so could result in a delay of claim coverage.

You may have a credit balance on your account after your insurance processes payment for today's visit. This would occur if you overpaid your deductible and/or coinsurance. By signing below you are allowing for us to retain any amount less than $10.00 to be applied to future visit or service payments.

Financial Responsibility

I hereby authorize payment of medical benefits directly to **Ayala ENT & Facial Plastic Surgery and Ayala Nasal Sinus Institute/Ayala Plastic Surgery Institute** and /or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the Patient's medical Insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to **Ayala ENT & Facial Plastic Surgery and Ayala Nasal Sinus Institute/Ayala Plastic Surgery Institute.**

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Patient Name (Please Print)

____ ______________________

Signature of Patient, Parent, or Legal Guardian **Date**

Address: 800 E. Dove Ave Suite F & G • McAllen, Texas 78504 Ph: 956-631-4515 Fax: 956-627-6015

Consent to Treat & Financial Responsibility

Please read and sign the following Statements

I hereby authorize employees including Physicians, Physician assistants and other employees/staff members to render medical treatment(s) and evaluations and care for the patient indicated below. I hereby authorized by signing the patient treatment and procedures consent form and any other forms that may be deemed necessary. I hereby authorize all benefits and payments from my insurance company (companies) for services provided and rendered to be paid directly to **Carlos Ayala, M.D. and Ayala ENT & Facial Plastic Surgery, PLLC.** I further understand that I am responsable for any charges not covered by my insurance company and/or companies , including Medicare. I also hereby authorize the reléase of any information concerning my health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I permit a copy of this authorization to be used in place of my original consent and signature. The duration of this consent is indefinite and continues until revoked in writing.

I understand that my insurance plan(s) **MAY NOT** cover the total cost of treatment(s) due to the nature of the insurance plan or that some treatment(s) **MAY NOT** be considered medically necessary by the insurance Company and that I am responsable for any co-payment, deductible and other charges not covered by primary or secondary insurance plan(s).

MEDICARE PATIENTS: I understand that I am responsable for the deductible and the co-payment applied to my medicare insurance coverage.

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Patient Name (Please Print

____ ______________________

Signature of Patient, Parent, or Legal Guardian **Date**

Complete this section ONLY if the patient is a minor

I consent for ______________________________ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures for the patient. The duration of this consent is indefinite and continues until revoked in writing.

____ ______________________

Signature of Patient, Parent, or Legal Guardian **Date**

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