ENT SPECIALISTS OF ARIZONA, PC
FINANCIAL POLICY

Patient Name:_____ Chart Number:_____

Patient Signature:_____ Date:_____

Thank you for choosing ENT Specialists of Arizona, PC as your healthcare provider. We are dedicated to providing personalized service for each patient.

The following policies are required to be read and initialed to acknowledge your understanding and agreement before your visit with us today. Please feel free to request a copy of this notice for your records.

I understand that if I have medical insurance, when billed on my behalf should reimburse the office for my visit(s) and procedural charges._____

I understand that it is my responsibility to pay all co-pays, deductibles, co-insurance and uncovered services that apply at the time of service._____

I understand that if for any reason my insurance company does not pay for the services provided within 90 days, then I shall assume full responsibility for the total amount owed._____

I understand there may be a $50 no-show fee applied to my account if I do not cancel my appointment 24 hours ahead of time._____

We accept cash, MasterCard, Visa, Discover, American Express, and money orders.
We do not accept personal checks.

1492 S Mill Ave, Suite 301, Tempe, Arizona 85281 • TEL: 480.894.5550 • FAX: 480.894.9469