

ENT For Kids | Surgery Financial Policy

RESCHEDULING / CANCELLATION POLICY AND FEES

Due to high demand and limited availability, and to provide the highest level of care and accommodation to all our patients, a cancellation/rescheduling & no-show policy has been established. **As a courtesy to other patients and our providers, we require 2 weeks' notice for all cancellations and reschedules. Failure to comply with this policy will result in a \$250.00 cancellation/rescheduling fee and/or significant delay in rescheduling.** This fee will be withheld from the paid surgery deposit when available or will be charged as a balance which must be paid prior to rescheduling surgery/scheduling office visit appointments.

A \$250.00 fee will be assessed for the following:

- Multiple cancellations/reschedules: Surgery may be rescheduled **one** time without penalty. We must be notified 2 weeks prior to the scheduled date. We make every effort to accommodate cancellations, however after two consecutive cancellations/reschedules we reserve the right to not reschedule your child's surgery.
- Failure to contact our office in the event that you need to cancel surgery
- Failure to make the **surgery deposit payment** on or before the due date
- Failure to obtain a **pre-op physical** with the pediatrician, resulting in surgery cancellation
- Failure to show on the date of scheduled surgery

No fee will be assessed in the event of cancellation/rescheduling by our office, or in the event of a documented medical reason with a doctor's note provided.

SURGERY DEPOSIT & ESTIMATE

If your insurance has a deductible, co-insurance or co-pay, a surgery deposit must be paid on or before the due date provided below. Generally, deposits are due **4 weeks prior to the surgery date**. If the surgery date is less than 4 weeks from the time of scheduling, the deposit is due **within 3 days of scheduling, or by the due date provided**.

We would like to make you aware that you will be billed from 3 separate entities for your surgery:

1. Surgeon's Fee: It is your responsibility to make your surgery payment on or before the deposit due date. You will receive an email from Phreesia titled *Payment Reminder from Florida Pediatric Associates* after scheduling. You can **click Pay Now** in the email to **make your payment online** or **call the office at 904-398-5437 option 1** with a credit or debit card to **make your payment over the phone**. We accept Visa, MasterCard, Discover and American Express.
2. Facility Fee (Center One Surgery Center, Jacksonville Surgery Center, or Wolfson Children's Hospital): We do not verify benefits or estimate financial responsibility for the facility or anesthesia. **We estimate and collect the surgeon's fee only**. Please contact the facility directly to find out your financial responsibility for these entities. Generally, the facility will collect at the time of service.
3. Anesthesia Fee: Will be billed to you after surgery.

Disclaimer: It is your responsibility to know your insurance benefits, which facilities are covered, and if prior authorization is required for surgery. Any cost quoted prior to your surgery is just an estimate. The final cost can only be determined by your insurance company, after your surgery, based on the insurance coverage and the procedures performed. Our office has verified your insurance benefits and will obtain authorization (if required) as a courtesy to you. Confirmation of benefits and/or authorization is not a guarantee of payment.

Deductible _____ Remaining Deductible _____ Coinsurance _____

Surgical Estimate/Deposit _____ Deposit Due Date _____

Other _____

Patient Name _____ Surgery Date _____

I have read and understand my responsibilities. I agree to the cancellation, rescheduling, and deposit policies and fees as outlined above.

Parent Signature _____ Date _____