

RUSSELL T. SNOW, D.O., P.A.
OTOLARYNGOLOGY (EAR, NOSE AND THROAT)
HEAD, NECK AND FACIAL PLASTIC SURGERY

PAYMENT POLICY

Welcome to our office and specialty services of Dr. Russell T. Snow. Please review our payment policy. Payment is expected when services are rendered. Please contact the receptionist if you have any questions.

FIRST VISIT: The **FIRST VISIT** is on a CASH basis except for Medicare and Medicaid.

CASH: Payment for office visits is due at the conclusion of each visit.

INSURANCE: As a courtesy to you we file claims for most insurance companies. Co-payments and unmet deductibles are due at each visit.

MEDICARE: Dr. Snow accepts "assignment." This means that Medicare pays 80% of allowed charges and you pay 20%. You are responsible for your yearly deductible. We file all Medicare claims.

MEDICAID: CURRENT Medicaid cards are necessary at EACH visit. Non-covered services are your responsibility for payment at the time of service. **We accept IDAHO MEDICAID ONLY. If you DO NOT have Medicaid at the time of service we will NOT back bill Medicaid for the visit.**

WORKMEN'S COMPENSATION: We will file your claim, but you will be responsible for payment if the claim is denied.

NOTE: YOUR INSURANCE IS NOT A SUBSTITUTE FOR PAYMENT. IF YOU CANNOT COMPLY WITH OUR POLICY, PLEASE SEE AN OFFICE STAFF MEMBER. THANK YOU.

**INTEREST WILL BE ADDED TO UNPAID ACCOUNTS AT 21% ANNUALLY.
ALL NON-COVERED CHARGES ARE YOUR RESPONSIBILITY**

PLEASE INDICATE METHOD OF PAYMENT BY CHECKING ONE OF THE FOLLOWING:

_____ I agree to pay for each visit at the time of service by
() Cash () Personal Check () Credit/Debt Card (3% surcharge on card transactions)

_____ I agree to pay my insurance portion (e.g. 20% or deductible) at the time of service. I agree to pay my Medicare deductible or co-pay on covered services and other amounts for which the patient is responsible.

_____ This is a Workmen's Compensation claim.

_____ I have a CURRENT Medicaid card. **If you DO NOT have Medicaid at the time of service we will NOT back bill Medicaid for the visit.**

I acknowledge the above policy and agree to comply.

Signature of Responsible Party

Date