Jackson Ear, Nose and Throat Clinic
Financial Responsibility Form

I understand I am responsible to The Jackson Ear, Nose and Throat Clinic for any charges not covered by my insurance carrier. Payment for service is due at the time of service unless prior arrangements have been made. I also agree if I fail to assume financial responsibility and credit action is necessary, I will pay those costs in addition to the amount charged.

I understand The Jackson Ear, Nose and Throat Clinic charges a returned check fee of $25.00. If my check is returned from the bank to The Jackson Ear, Nose and Throat Clinic, I will assume responsibility for this fee and replace the returned check with a money order or cash. If I fail to assume financial responsibility and credit action is necessary, I will pay those costs in addition to the amount of the returned check and returned check fee.

I also understand The Jackson Ear, Nose and Throat Clinic participates in the following networks:

Blue Cross Blue Shield
State of MS Employees
Chips
MS Health Partners
American Lifecare
MS Physicians Care Network
United Healthcare

If my insurance participates in any PPO or network that The Jackson Ear, Nose and Throat Clinic doesn't belong, I understand benefits will be paid at the out of network rate and I will be responsible for any remaining balance.

The 1993 Defense Appropriations Act limits the amount that non-participating providers can charge a patient on payable services to 115% of the Champus allowable. Since The Jackson Ear, Nose and Throat Clinic doesn't participate with Champus, I agree to pay any additional amount charged and not covered by Champus.

Signature: _____
Patient/Guarantor

Patient Name: _____

Date: _____