

**JACQUELINE JONES, M.D.**  
**Acknowledgement of Financial & Privacy Practice Policies**

**Dear Patients:**

Welcome to our office! Our goal is to provide the highest standard of patient care and it is essential that we establish a clear understanding of our Financial & Privacy Policy with our patients. Should you have questions or concerns about our fees, policy, your financial responsibility or our privacy practices, please do not hesitate to ask.

**IN-NETWORK INSURANCE** - If Dr. Jones is considered "in-network" with your carrier, you are responsible for all co-payments at the time of service. You may also have in network deductibles and coinsurance and you will be required to leave a credit card on file with our office. Once we receive the EOB from your insurance carrier, we will send 1(one) statement. If we do not receive prompt payment, we will automatically charge the card we have on file.

**OUT-OF-NETWORK INSURANCE** - We ask for payment in full at the time of service and as a courtesy, we will gladly submit the claim form to your insurance carrier for your reimbursement consideration. Dr. Jones' team is committed to maximizing your insurance benefits and will work closely with you and your insurance carrier. Please contact your insurance company directly for details regarding your out-of-net work coverage.

**SELF PAY PATIENTS & INTERNATIONAL INSURANCE** - We ask for payment in full at the time of service and will provide you with a receipt for your records.

**MEDICARE & MEDICAID PATIENTS** - Dr. Jones does not accept Medicare or Medicaid and you will be responsible for payment at time of service. We will also require you to sign a Medicare release form.

**REFERRALS** - If your insurance company requires a referral to see a specialist, it is your responsibility to obtain this document prior to the appointment. Please remember that referrals expire and you are responsible for renewing with your primary care physician or pediatrician. If you do not obtain a referral, you will be responsible for the entire bill.

**CANCELLATION POLICY** - We understand that unexpected events occur and we ask that you contact the office as soon as possible to cancel or reschedule your appointment. In the event you do not arrive, the fee is \$100. We ask you arrive promptly to your appointment as we want to provide as much undivided attention and care to you and your family. If you are more than 10 minutes late to your appointment we will consider you a "fit in" patient and will be seen when time allows.

**DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** - The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Dr. Jacqueline Jones or her staff will not be involved with separation or divorce disputes regarding payment and/or services.

**PAYMENT METHODS** - We accept Visa, MasterCard, American Express, checks and cash.

**DIAGNOSTIC PROCEDURES** - During the process of your evaluation and management by Dr. Jacqueline Jones, she may deem it appropriate and necessary to more closely examine your ears, nose, and/or throat using commonly tried and tested methods and in-office mildly invasive diagnostic procedures. Your insurance company may list these codes as surgical in nature even though they are performed in-office. Such procedures can include, but not limited to, Nasal Sinus Endoscopy (31231), Laryngoscopy (31575), Cerumen Removal (69210), and hearing exams. These procedures are the doctor's only tools to be better able to diagnose and treat your medical issues. You will be financially responsible for anything applied to your deductible and/or co-insurance arising from the billing of these codes.

**AGREEMENT**

*I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Jacqueline Jones or my insurance company to release any information required to process my claims.*

*I have had full opportunity to read and consider the contents of your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment; payment activities and health care operations.*

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_  
Print Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

How would you like your appointments to be confirmed (Check all that apply):

Home     Cell     Email     Text     Other: \_\_\_\_\_

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