OAKDALE EAR NOSE & THROAT CLINIC, P.A.
3366 OAKDALE AVE NORTH, SUITE 150
MINNEAPOLIS, MN. 55422
FAX: (763) 520-1578

SURGICAL / POSTOPERATIVE FINANCIAL AGREEMENT

Patient Name: ____ Date: ______________

Responsible Party: ____

Proposed Surgery (__________)____

(___________)____

(___________)____

(___________)____

Date of Surgery __________

If Oakdale Ear Nose & Throat Clinic, P.A. is not contracted with my insurance company, I am ultimately responsible for any balance that my insurance plan does not cover for surgical and/or postoperative care. If Oakdale Ear Nose & Throat Clinic, P.A. is contracted with my insurance company, our office will follow their rules for assigning a balance to you. Our office cannot guarantee the amounts of coverage offered by your insurance company, as each policy is different.

Insured's Responsibility

1. Although we check for eligibility and prior authorization, it is your responsibility to know what requirements your insurance company has for your individual policy. It is advised that you call your insurance to see of you need a referral and if the facility is covered location.

2. If you want to check your benefits, call the telephone number on your card. They may ask for the CPT codes. Most of those are listed above along with your procedure. We do not check benefits, only eligibility.

Please sign and return this form in the enclosed envelope. If this form is not returned at least two business days prior to surgery, your surgery may be canceled. If you have any questions, please contact Kathleen H. (763) 520-7233 or Rhonda L (763) 520-3933..

PATIENT SIGNATURE: ______________________________________
DATE: ______________

PARENT SIGNATURE IF MINOR: ______________________________
DATE: ______________