ENT Oregon Ear, Nose & Throat Center
541-779-7331

To Our Valued Patients:

Thank you for choosing Oregon Ear, Nose and Throat Center for your ENT care. Our physicians and staff are committed to providing you with the best care possible.

The following is an explanation of how our services are billed to your insurance company. In addition to your office visit charge, you may also receive additional charges if you have any of the following: nasal endoscopy (this allows the physician to better visualize your nasal passages as well as treat certain sinus conditions), laryngoscopy (this is for the evaluation of throat concerns), binocular microscopy (this involves the use of a microscope during the examination of your ears), cerumen extraction (earwax removal), cautery of the nose (to control bleeding), diagnostic audiology testing or if the physician performs any other procedure during the visit.

When you receive your explanation of benefits from your insurance company, you will see these items listed and billed separately as part of the services you received. Some insurance companies may also classify these as “procedures.”

In addition, we recommend you contact your insurance company before your appointment if you are unsure of your benefits or have questions regarding coverage. It is ultimately your responsibility to know how your insurance processes payment for services rendered. If you have questions regarding costs, please call our billing department prior to your appointment.

If you have been seen by any another ENT doctors or health care facility, and/or have had or plan to have any imaging done, please complete and return the enclosed authorization to use/disclose health information form so that we may obtain copies for review prior to your scheduled appointment.

Thank you.

I hereby acknowledge that I have read, understand and agree to the terms of this document relating to insurance coverage and payment for services.

I consent to medical photographs to be taken of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record or for authorization purposes.

Patient/Responsible Party Signature: _____ Date: _____