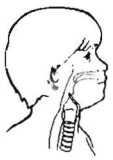

Children's Ear, Nose & Throat Specialists, PLLC

* **John P. Little, M.D.**
Board Certified
Fellowship Trained

Michael J. Belmont, M.D.
Board Certified
Fellowship Trained

R. Mark Ray, M.D.
Board Certified
Fellowship Trained

Aimee Biddle, Au.D.
CCC-A
Kristie Johnston, Au.D.
CCC-A
Natalie Murphy, Au.D.
CCC-A
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Pediatric Audiologists

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* Implant Surgeon,
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Knoxville, TN 37916

865-521-6005
fax 865-521-6088

Specializing in Pediatric Otolaryngology providing Head and Neck medical and surgical care for children and adolescents (birth - 21 years)

FINANCIAL AGREEMENT

Please <u>initial</u> by each asterisk and sign at the bottom of the form

*_____ I hereby assign to Children's Ear, Nose & Throat Specialists, PLLC (the "Practice") all payments for medical services provided to me or my dependents.

*_____ I understand that the payment of my portion of the Practice's charges is expected when services are rendered.

*_____ I understand that I am responsible for any appropriate charges not paid by my insurance company, managed care, government, or other provider. I also understand that it is my responsibility, not the Practice's responsibility, to know what services are covered and not covered by my insurance company. If I fail to provide the correct insurance information and the claim is denied for timely filing, I will be responsible for the charges.

*_____ I understand that a financial account that is not current may result in the rescheduling of my/my child's appointment for non-urgent care. In this situation, if urgent medical care is required then the patient should be taken to the Emergency Department of East Tennessee Children's Hospital for further evaluation where our Practice may be consulted if necessary.

*_____ I understand that whoever brings my child for evaluation and treatment will be responsible for payment of any charges. In cases of divorce, unmarried parents, or other custodial situations, I understand that the Practice is not responsible for identifying who is responsible for the payment.

*_____ I understand that 24 hours notice is requested for cancellation/ rescheduling of an appointment and that excessive abuse of missed appointments may result in a fee (and/or discharge) from the practice.

*_____ I understand that if the portion of the bill for which I am responsible is unpaid, I will be turned over to a collection agency. In the event this account is turned over for collection, patient (or responsible party) agrees to pay for all costs of collections, including court costs and attorney fees.

_____
Signature

_____
Printed Name

_____
Date