# Virgin Islands Ear, Nose & Throat

Adam M. Shapiro, MD, F.A.C.S.
Joseph Ryan Smolarz, MD, F.A.C.S.
Gavin M. Gassen, MD

## Payment Authorization

***Full payment is expected when services are rendered. Thank you.***

Patient Name - First _____ Middle Initial _____ Last _____

## For Patients with Accepted Insurance Plans:

**Primary Insurance Company** _____

Policy No. _____ Group No. _____ Subscriber Name _____

Subscriber Date of Birth _____ Subscriber Social Security No. _____

Subscriber Relationship to Patient (please select one) ○ Self ○ Spouse ○ Parent ○ Other

**Secondary Insurance Company** _____

Policy No. _____ Group No. _____ Subscriber Name _____

Subscriber Date of Birth _____ Subscriber Social Security No. _____

Subscriber Relationship to Patient (please select one) ○ Self ○ Spouse ○ Parent ○ Other

**Tertiary/Other Insurance Company** _____ Policy No. _____

This certifies that the above named insurance policy(s) are the only insurance coverage(s) for this patient. I request that payment of authorized insurance benefits be made on my behalf to *Virgin Islands Ear, Nose & Throat* for any services rendered. I authorize any holder of hospital or medical information to release to the appropriate insurance company and its agents any information needed to determine the benefits payable for related services. **In the event the provider's charges exceed my insurance carrier's payment or services are not covered by my insurance, I understand that I will be responsible for paying the difference.**

## For Patients with No Insurance

**Self-Pay Patients please read the following:**

I recognize that (enter name of patient or parent/guardian) _____ is solely responsible for the charges associated with the care given by *Virgin Islands Ear, Nose and Throat* and that payment is due at the time services are rendered. **By signing below I certify that I do not have coverage with Medical Assistance (MAP) and/or Medicare.**

**Security cameras:** I understand that for security reasons the premises, to include the examination rooms, may be monitored by video surveillance.
**Missed Appointments:** will result in a $25.00 fee unless our office is notified of the cancellation 24 hours prior to the appointment.
**Unpaid balances:** Any account balance over 60 days will be subject to an interest rate of 18.5%.

_____ _____
Patient or Parent/Guardian Signature Date of Appointment

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Paragon Medical Building, Suite 308
9149 Estate Thomas
St. Thomas, Virgin Islands 00802
(340) 774-8881

4000 Beeston Hill Medical Center, Suite 8
St. Croix, United States Virgin Islands 00820
(340) 773-8801