Audubon
3030 N. Circle Dr., Ste. 300
Colorado Springs, CO 80909

St. Peregrine
6031 E. Woodmen Rd., Ste. 300
Colorado Springs, CO 80923

Park West
3595 E. Spaulding Ave, Ste. B
Pueblo, CO 81008

Self-Pay Patient Financial Consent

Self-Pay Patient Financial Responsibility Agreement
Thank you for choosing our practice for your healthcare needs. As a self-pay patient, you acknowledge and agree to the following financial terms:

1. Deposit
   - A $300.00 deposit is required prior to your appointment.
   - This deposit is not an additional fee and will be applied towards your total account balance for services provided during your visit.
2. Balance Due
   - **If the total cost of your visit exceeds the $300.00 deposit, you are responsible for paying the remaining balance.**
3. Additional Services
   - The deposit covers only the services provided by our practice during your visit. Depending on your medical needs, additional services may be recommended or performed that result in separate charges.
   - These may include, but are not limited to:
     - Diagnostic nasal endoscopy or laryngoscopy
     - Flexible fiberoptic laryngoscopy
     - Ear microscopy or cerumen (earwax) removal
     - Hearing evaluations and audiologic testing
     - Tympanometry or other middle ear testing
     - Biopsies or other in-office procedures
     - Allergy testing (when applicable)
     - Imaging studies, such as CT scans
     - Laboratory or pathology services
4. Separate Billing
   - You understand that you may receive additional bills from our practice or from third-party providers and facilities for services not included in the initial deposit.
   - These charges are your financial responsibility and are due upon receipt of the bill unless other payment arrangements have been made.

By signing below, you acknowledge that you have read and understand this Financial Responsibility **Agreement, agree to the $300.00 deposit, understand that it will be applied toward your account balance, and accept responsibility for any additional charges incurred during your care.**

Patient Name: _____

Signature: _____

Date: _____