Illinois Gastroenterology Group
IGG

# Financial Policy

Thank you for choosing Illinois Gastroenterology Group, LLC as your healthcare provider. We are committed to providing you with the best possible medical care for the successful treatment of your condition. If you have special needs we are here to work with you. Your clear understanding of our Financial Policy is important to our professional relationship. We request you read and sign below. A copy will be returned for your records. Please contact our Billing Department if you have any questions at 847-244-6320. Our office participates with a variety of insurance plans. It is your responsibility to:

- Bring your insurance card to every visit.
- Be prepared to pay your co-pay at each visit. Payment may be made by cash, check, or credit card.
- For medical care not covered under your insurance, payment in full is due at the time of the service - unless prior arrangements have been made with our billing department.

## Self-Pay

"Self-Pay" is defined by IGG as a patient who does not have insurance or a program that accepts financial responsibility for the patient's bills. In these circumstances, we may offer discounted self-pay rates and/or bundled service options. We expect payment at the time of service unless prior arrangements have been made with our Billing Dept. If you are unable to pay for necessary medical care, it is your responsibility to inform us prior to the visit.

## Medicare

IGG accepts Medicare assignment. As a Medicare patient you are responsible for the difference between the approved charge and the amount Medicare pays, plus your deductible. If you have supplemental insurance we will be happy to electronically submit it for you. You will receive a bill after your insurance has paid.

## HMO/PPO

All co-payments are due at the time of the service. We are members of most but not all plans. You are responsible for verifying that we are providers for your plan. If you are an HMO member you must provide us with a referral form at the time of the service. It is the patient's responsibility to know your insurance and to know when referrals or pre-authorization is required. If you do not have a referral, your visit may be rescheduled, or you may be financially responsible.

## Insurance

As a courtesy to our patients, we electronically submit your claims to your insurance company. Please keep in mind, however, that your insurance policy is a contract between you and your insurance company. Our practice is not a part of that contract. We cannot bill your insurance company unless you provide us with all required insurance information including a copy of your card and a signed assignment of benefits form. It is your responsibility to determine what benefits are covered by your insurance plan. The balance of your account is always your responsibility. If your insurance company has not paid your claim in 45 days, the balance will be transferred to you and becomes your responsibility.

## Cancellation Policy

Cancellation of an appointment is required 24-hours in advance of the scheduled appointment. Office appointments which are missed without notification may be subject to a $50.00 cancellation fee. Procedure cancellations require 5-7 business day advance notice. Without notification, they may be subject to a $150.00 cancellation fee. In addition, patients who no-show two (2) or more times in a 12 month period, may be dismissed from the practice. Providing advance notice is not only a courtesy to your physician but provides opportunity for another patient in need to be seen. Special unavoidable circumstances will be reviewed for consideration.

## Surgical Procedures

If you are scheduled for a surgical procedure by our office at a local hospital or an ambulatory surgical center, please be aware there are separate service components for which you will be billed separately:

1. Physician's Professional Charge. Your physician will bill this charge separately to you. This billing is for the physician's professional services that are provided during your procedure.
2. Facility Charge. This billing is for the use of the Hospital or Ambulatory Surgery Center in which your procedure is being performed.
3. Laboratory and Pathology Charge. If you have blood drawn and or/a biopsy taken you will receive a bill from the laboratory and pathologist that processes your blood work or biopsy.
4. Anesthesia Professional Charge. If your procedure utilizes the services of an aesthetician, this professional charge will be billed separately to you.

## Medical Record Copying

All medical record copy requests must be in writing, dated, signed, and designate where the records are to be sent and what documents are to be copied. The medical information is accessible to the patient or their representative with signed authorization. The cost associated with copying medical records is made payable in advance and dependent on the number of pages. Our medical records department will provide you with the fee information and time frame for processing your request after review of your chart. Copies of records for the purpose of referral or continuation of patient's medical care does not have an associated cost.

## Form Fee Procedure

Below are the current fees that will be charged on our frequently requested forms.

1. Routine school/work physical exam form: $25   Handicap forms: $5
2. Disability forms: $35
3. Personal Letters (employment, airline, life insurance etc. - non-excuse): $15
4. FMLA forms: $35
5. Assisted Living forms: $15

## Non-Sufficient Funds (NSF)

Returned checks will incur a $25.00 service fee for the first check. Second NSF will result in a $50.00 service fee and patient will be on a cash or credit card payment basis only.

## Collection

In the event of non-payment of the Doctor's bill, the Doctor shall be entitled to the right of recovery for all collection expenses, including court costs and reasonable attorney's fees, incurred for the purpose of obtaining payment of the amount due. If your account does go to a collection agency or we are listed in a bankruptcy suit you may be dismissed as a patient from our practice at your physician's discretion.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the Billing Department

Please sign indicating that you have read, understand and agree to this Financial Policy

_______________________________________________

Patient Name (please print)

_______________________________________________ Date_____________________________

Signature of Patient or Patient Representative