Financial Policy

Office and Financial Policies

Thank you for choosing Illinois Urological Institute, S.C. We are committed to the success of your treatment and care. Please understand that payment of your bill is part of this treatment and care. The following is our statement of Financial Policy which we require our patients to read, understand and sign prior to any treatment or care. Please request a copy for your files if desired.

Patient Online Portal:

Please sign up for the Patient Portal. Simply request an email invitation from a member of our staff.

- View your records and test results online
- Email secure communications and questions to the staff

Credit Card Policy:

We require a valid Credit Card on file as security towards any balance you may owe after insurance processing and in accordance with your insurance contract.

- *We will only bill the Credit Card for patient services if no payment is received within 60 days and no other arrangements are made.*
- *We will only bill your portion in accordance with your insurance contract.*
- *We may also bill your credit card for missed appointments, returned checks, and administrative fees outlined below, ranging from $25-$100..*
- *You reserve the right to challenge any charges.*

Insurance Cards and Identification:

Please bring your insurance card to each appointment. Please provide requested patient identification information and promptly pay all patient portions due.

Payment of co-pays is required on arrival for office visits.

Your appointment may be rescheduled otherwise. This is a requirement of your Insurer. We accept Cash, Visa, MasterCard, Discover, and Personal Checks.

Patients presenting with Medicare and no secondary or supplemental insurance will be asked to pay their 20% Medicare coinsurance or Medicare Replacement Plan co-payment and/or coinsurance at the time of service.

You will receive a bill for additional patient portion or deductibles after insurance processing. Payment is due within 30 days unless payment arrangements are made.

Note: We require pre-payment of the expected patient portion before certain elective surgeries.

HMO or POS:

For POS and HMO insurance plans, your insurance carrier requires that you obtain a referral from your Primary Care Physician (PCP) before receiving services. Please bring that referral with you. *You may be rescheduled or have to pay out of pocket otherwise.* Any services received without a proper referral or proper authorization will be your financial responsibility.

Insurance Pre-Authorization and/or Pre-Certification:

You should contact your insurance company prior to scheduling any procedures or testing to see if prior authorization is required, and follow their instructions. Failure to obtain appropriate authorization may increase your share of the cost.

Workers Compensation:
We do not provide services for any work-related injuries or injuries sustained through an accident.

Illinois Department of Public Aid (Medicaid/All Kids/Family Care)
We are not providers for *any* medical assistance programs administered through the Illinois Department of Healthcare and Family Services (HFS), and these programs DO NOT pay for out-of network care. Payment *in full* will be due at the time of service. A significant cash discount in your favor will be applied to your charges. We highly encourage patients with these plans to locate a Physician in-network.

Uninsured/Cash Pay Patients:
Payment *in full* will be due at the time of service and before any planned surgery. A significant cash discount in your favor will be applied to your charges. If you are unable to pay your balance in full, you will need to make prior arrangements with our business office.

Surgical Services and Post-Operative Care:
Some surgical fees include routine, uncomplicated post op care for 10 – 90 days. You will still be responsible for co-payment and deductibles for labs, x-rays, and unrelated or non-routine treatment during any post-operative periods.

Administrative Fees:

- **No-Show Appointments/Cancellation of appointment less than 24hrs prior: $35**
- **No-Show Procedures/Surgeries or Cancellation less than 24 hours prior: $100**
- **Return Checks/Rejected ACH Withdrawals: $30**
- **Disability or Insurance Forms: $25 + mailing costs.** Payment is due at the time that you pick up the forms. Please allow 7-10 days for completion of these forms. If you would like the forms mailed to you or your insurance company, mailing costs are added.
- **Medical Records: Varies. Per Illinois Statute.** We will provide you a copy of your medical records upon request. Pursuant to Illinois Statute, you may be charged for these records and payment is required prior to the release of any records. You will need to sign a letter of release prior to release of your records. Please allow 7-10 days for us to process your request. If you wish for your records to be mailed, there may be an associated fee to cover the mailing costs. You may be charged for additional copies of your medical record.

Delinquent Accounts and Collections:
Do not ignore your bills. If needed, talk to our staff about payment arrangements. Failure to make payment arrangements on an outstanding balance within 90 days may result in your account being sent to a collection agency or attorney for further action. If your account goes to collections, you will owe much more than your original bill. In addition to the principal amount owed to IUI you will also incur additional charges of 30% of the unpaid balance as collection agency fees, as well as any additional fees including but not limited to court costs, interest as allowed by law, and attorney and filing fees.

Insurance Questions**:** Our staff has been trained to understand how to properly bill insurance on your behalf, but we do not have many of the details of your insurance contract. Please contact your employer or insurance company should you need more detailed information about your coverage.

Thank you for reading and understanding our Financial Policy. Please let us know if you have any questions or concerns.

I HAVE READ THE FINANCIAL POLICY. FURTHERMORE, I UNDERSTAND AND AGREE TO THE POLICY.

____ ____________________
Print Patient’s Name Date

____ ____________________
Signature of Patient or Responsible Party Date