FINANCIAL POLICY

Thank you for choosing us as your health care providers. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask our billing department if you have any questions about fees or our Financial Policy.

INSURANCE POLICY

- Every person's Insurance Plan is different and only you can be responsible for knowing your plan.
- In order for us to bill your insurer for services rendered, it is your responsibility to provide our staff with a copy of a valid insurance card. We can make a copy of your card for our records. Failure to provide a correct insurance card at the time of service or request a re-bill with corrected information will incur a $25 administrative charge.
- For New Patients: If you do not have the insurance card at the time of the visit, 100% of visit charges are due at the time of service.
- In plans where we are a participating provider, all copays and deductibles are due and payable at the time of visit/treatment. There are many national insurers and payers and/or plans that we participate with and are an "in-network provider". It is your responsibility to know/ensure if we are a participating provider with your insurance and your particular plan.
- If you do visit us as an out-of-network patient, we could bill for you out of courtesy, but we do require you to pay in full at the time of visit/treatment.
- Some services provided may not be covered services under your plan/policy. Whether the insurance company pays or not for the unpaid balance amount, it is your responsibility if the services were deemed necessary by the provider or requested by you.
- Multiple Insurance Coverage
    - New or existing: if you have multiple insurance coverages, it is your responsibility to inform us of all coverages and ensure to complete Insurance Information section of New Patient Insurance Information Form for billing preferences, that is which one to be billed as primary of secondary.
- Pre-Certification/Pre-authorization
    - If your insurer requires precertification prior to Office visit, In-Patient/Out-Patient Hospital Stay/Services, Laboratory Testing, Medications or Ultrasounds, we will work with you as a courtesy, in getting pre-certification done. However, it is your responsibility to ensure all services availed by you are approved by your insurer.
- College Student Covered Under Parent's Insurance
    - If you are a college student and covered under your parent's insurance plan, it is required that you fill our Student Status Verification Form and send it to the insurance companies each semester. If insurance database is not updated accordingly, insurance company will not pay the claim and you and/or your parent assume the responsibility of entire balance.
- HMO Plans and Referral Requirements
    - Referral is required by HMO Plan is strictly the patient's responsibility and should be obtained and presented prior to any treatment. If the physician sends you for outside tests/other specialist evaluation and referrals are necessary, you must inform us and allow ample time to receive the referral prior to scheduled tests/specialist appointment.

Initials:____ Date:_____

PATIENT SHARES/RESPONSIBILITIES

CLAIMS UNPAID OVER 90 DAYS: If your insurance has not paid within 90 days of the filing of our claim, the balance will become patient's responsibility regardless of REASON FOR REJECTION/DENIAL

COPAYS/COINSURANCE/DEDUCTIBLES: These charges fall under Patient Responsibility and must be paid before receiving any treatment

PAST DUE BALANCE: All previous balances need to be cleared before receiving any further services. Unpaid balances might require a re-scheduling of your appointment unless a prior arrangement/payment plan is in place. Finance charges will be applied for all unpaid balances after 30 days.

RETURNED CHECKS: Returned checks are subject to $25.00 service charge

DECLINED CC TRANSACTIONS: Declined credit card transactions with signed/agreed Auto Authorized Installment payments in place are subject to a $12.00 service charge

FORMS AND NOTES: There is an administrative fee for all forms, notes and year-end payment reports. Payment is due prior to note/forms being provided to patient.

RELEASE OF MEDICAL RECORDS: Copies of medical records will be given to the patient after all fees are paid. The fees for medical records are as per rule of the State of Illinois Comptroller's office.

HOW WE BILL YOU FOR SERVICES RENDERED:

As indicated above, all services are required to be paid up front including copays/ coinsurances/deductibles. We have Cost Estimation Tools for visits to Physician Offices for different services to arrive at exact Patient Share Responsibility. We trust you for clearing your dues as a priority and once we bill you for Patient Responsibility or Patient Share portion for services rendered, claim filed and adjudicated by your insurance company.

As a general policy we bill based upon EOB/P (Explanation of Benefits/Payments) issued by the Insurance Company for services rendered/claimed; you would receive your copy of EOP/P in mail from your insurance company establishing billed charges as your responsibility. **WE STRONGLY ENCOURAGE YOU TO GO TO YOUR INSURER'S WEBSITE UNDER MEMBER LOGIN TO SEE YOUR EOB.** We can also provide you with a copy of EOB/EOP for a nominal fee of $25/EOB. Specifics of your Statement will be provided in your Statement.

Your bill is available for you to see on your secure portal. We bill you once a month via USPS first class mailing. In order to be in control of your dues please ensure that your mailing and emailing addresses are accurate and up to date in our medical records.

Initials: ____ Date:_____

NO SHOW/LATE CANCELLATION POLICY

This policy has been established to better serve you as well as all patients. When an appointment is made, it removes the ability for other patients to be seen efficiently. No-Shows and Late Cancellations cause a delay in delivery of health care to other patients.

A "No Show" is missing a scheduled appointment without prior notice. A "**Late Cancellation**" is cancelling an appointment without calling 24 hours in advance of an office visit or 48 hours in advance of a procedure.

A charge of $25 will be assessed for each No Show or Late Cancellation less than 24 hours prior to appointment.

A charge of $200 will be assessed for each No Show or Late Cancellation less than 48 hours prior to procedure appointment.

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be addressed on a case-by-case basis.

If you are more than 10 minutes late for a scheduled appointment, you may be asked to reschedule and/or wait until the doctor can see you.

ASSIGNMENT, AUTHORIZATION, POWER OF ATTORNEY AND AGREEMENT

I appoint this office as attorney-in-fact to correspond on my behalf with insurance companies, to negotiate any settlement and to cash any settlement draft or check, to counsel and advise insurance companies that no settlement can be effectuated without the agreement of this office. I fully understand and agree to be responsible for any legal interest on the indebtedness, together with such collection costs, including but not limited to fees for investigation, skip tracing, credit report, court reporter, filing and processing and reasonable attorney costs as required to effect collection. An administration fee will be assessed to my account, if my account goes to collections.

I understand that if this office receives more than my deposit, the office will pay any credit balances to me by corporation check after my verbal/written request.

I hereby grant permission to the doctors and/or authorized personnel to administer medication and perform such procedures as may be deemed necessary in the interest of my health.

I authorize medical records (PHI) and/or receipts to be sent to me via the internet. (email/fax). A photocopy or scanned copy of this form shall be considered as valid as original.

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Signature of patient/responsible party Date

Your signing/accepting of this General Financial Policy ensures that we agree on billing/payment issues pertaining to patient share/responsibility towards medical services rendered to you.