Carlos Rotman, MD, FACOG, FACS
2425 West 22nd Street, Suite 103 • Oak Brook, Illinois 60523
Phone (630) 990-2440 • Fax (630) 990-2441

PATIENT FINANCIAL POLICY AND INFORMED CONSENT

Thank you for entrusting your health to Dr. Carlos Rotman and his associates. In addition to our commitment to offering you the highest quality medical care, our staff is dedicated to ensuring a positive outcome for your entire experience. For that reason, we have prepared this financial policy for you to read and sign prior to commencing treatment.

Payment for Services. Please understand that payment for healthcare services is considered a part of your treatment. We accept cash, checks, Visa, Mastercard, and Discover.

Uninsured Patients. Payment in full is due at the time of service. If you are unable to pay your balance in full, you must make arrangements in writing with the Financial Coordinator before your appointment.

Insured Patients. Please bring your insurance card with you at the time of your appointment. We participate in many insurance plans. If you are insured by a plan with which we do not do business, we will make every effort to verify coverage before your visit, but payment in full is due at the time of service until we can verify coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-Payments, Deductibles, and Co-Insurance. All co-pays and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. If we do not collect co-pays and deductibles from our patients, it can be considered insurance fraud. Please help us to uphold the law by making your co-pay/deductible payment at each visit.

In addition to making co-pays and meeting your deductible, you are responsible for any co-insurance not paid by your insurance within the state's required time limitation for paying healthcare claims. You will receive a statement from our office indicating what your insurance has paid. Any balance remaining is due upon receipt.

Non-Covered Services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by some insurers. You must pay for these services in full at the time of service.

HMO or POS. Contracted insurance carriers require that you obtain a referral from your Primary Care Provider (PCP) before receiving services from another provider. Please bring that referral with you. It is your responsibility to know your insurance requirements. Any services received without a referral or proper authorization will be your responsibility.

Proof of Insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license or valid government identification and current insurance card to provide proof of insurance. If you do not provide us with the correct insurance information in a timely manner, you may be responsible for the full amount of the claim.

Insurance Claims Submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim. Your insurance plan is a contract between you and your insurance company – we are not a party to that contract.

Insurance Coverage Changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will be automatically billed to you.

Nonpayment. If your account is more than 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless you make arrangements in advance and sign a payment plan. Please be aware that, if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If that happens, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30 day period, you will be eligible to receive only emergency treatment.

Carlos Rotman, MD, FACOG, FACS
2425 West 22nd Street, Suite 103 • Oak Brook, Illinois 60523
Phone (630) 990-2440 • Fax (630) 990-2441

Minors. For children under the age of 18, and adult is responsible for payment. In addition, minors cannot receive medical treatment without the written consent of a parent or legal guardian.

Returned Checks. A $30 charge will be added to your account for any check returned by your bank for any reason.

Medical Records. We will provide you with a copy of your medical records upon request. You will need to sign a letter of release before we can deliver them. Please allow 7-10 days for us to copy your records.

Patient's Name______________________________ Date of Birth______________

Parent/Guardian's Name______________________________ Date of Birth______________
Relationship to Patient______________________________

Patient's Statement of Financial Responsibility. I have read, understood, and agree to the terms of this Patient Financial Policy. I acknowledge full financial responsibility for any services rendered by Dr. Carlos Rotman and his associates. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including co-pays, deductibles, and co-insurance. I understand payment of co-pays is expected at the time of service, as well as any prior balance I may owe. I also consent that the payment of authorized insurance benefits be made on the patient's behalf directly to Dr. Rotman for any medical or surgical services rendered. I agree to all reasonable attorney fees and collection costs in the event of default of payment of my charges.

Patient's Signature______________________________ Date______________

Consent for Purposes of Treatment, Payment, and Healthcare Operations. I hereby give my consent to Dr. Carlos Rotman and his associates, and the nurses and staff under their direction, to conduct any examinations, and administer treatment and medications, as they deem necessary or advisable. I understand that Dr. Carlos Rotman may request that photos of me be included in my medical record, and that I must inform the office staff if I do not want their inclusion. I authorize them to use or disclose all protected health information contained in my patient record for the purpose of carrying out treatment, payment, or healthcare operations. I understand that a more detailed description of this consent and other uses and disclosures is contained in the Notice of Privacy Practices specified below, that Dr. Carlos Rotman reserves the right to change these privacy practices, and that any changes will be posted at his office and may be sent to me by mail upon request.

I further give my consent to Dr. Carlos Rotman and his associates to call my home or alternative location listed in my registration, and leave a message on voicemail or in person, or to mail to my home or alternative location any items that assist the practice in carrying out treatment, payment, and healthcare operations, including, but not limited to, appointment reminders, insurance items, and laboratory tests.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving notice of my desire to do so, in writing, and delivered to the physician's office. I also understand that I will not be able to revoke this consent in cases where Dr. Carlos Rotman and his associates have already relied on it to use or disclose my health information.

Patient's Signature______________________________ Date______________

Acknowledgement – Notice of Privacy Practices. I hereby acknowledge that I have been given a copy of Dr. Carlos Rotman's Notice of Privacy Practices, which provides detailed information about how the practice may use and disclose my confidential health information. I understand that Dr. Carlos Rotman reserves the right to change these privacy practices, and that any changes will be posted at his office and may be sent to me by mail upon request.

Patient's Signature______________________________ Date______________

Witness's Signature______________________________ Date______________