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INSURANCE ASSIGNMENT AND PAYMENT POLICY

All patients please read carefully:
The following is our office policy regarding payment for treatment and insurance assignment. Our office maintains that every patient is entitled to the highest quality of medical care that can be provided. Your health and well-being are our primary concern; therefore, we feel that it is important to our patients to completely understand their treatment and fees involved. By signing this agreement, you are stating that you understand and agree to the following:

1. You are considered a cash patient until you provide current insurance forms/information, and/or this office receives verification of benefits. Our office can assist you in the verification of benefits, however this is not a guarantee due to insurance disclaimers. We cannot be responsible for misinformation or lack of cooperation from your insurance company. You understand that as the policyholder or covered dependent, it is your responsibility to know your company's benefits, requirements, and exclusions for treatment.

2. You agree to pay all fees in full on the date of treatment either by check, cash, or credit card if your insurance benefits cannot be determined by the above guidelines unless other arrangements have been made prior to your appointment. You understand that regardless of your insurance coverage, you are responsible for any and all fees incurred during your treatment.

3. You understand that it is your responsibility to be aware of your insurance requirements and referrals. You also understand that all managed care (HMO) referrals must be in place PRIOR to treatment. If a referral is necessary, our office will assist you in obtaining your referral for services.

4. INSURANCE COVERAGE: Insurance companies rarely reimburse the full amount of medical visits and treatments, usually paying between 50% and 80% of the cost depending on the insurer. This office quotes fees that are within the usual and customary range of allergy and asthma practices in our area. Many companies pay from their own fee schedules. All coverage is subject to co-pays and deductibles. We are happy to file insurance claims, as a courtesy to you, but this office cannot accept responsibility for collecting your insurance claim for you or negotiating settlement for you on a disputed claim. Your coverage is a contract between you and your insurance company.

5. All account balances must be paid in full at the time of receipt of your statement. Failure to pay your account in full without contacting our billing department before the next billing period will result in being sent to pre-collections and subsequently collections. We offer monthly recurring payments of balances with credit card securely on file, please contact our office for more on this option.

6. If your account is turned over to an outside collection agency you will be dismissed as a patient and asked to seek care from another provider. We will assist in getting records transferred. If you wish to return as an active patient all financial obligations must be paid in full. This includes your balance, collection fees, attorney fees and court costs. You will be required to pay at time of service for any future appointments.

7. Any bounced or non-sufficient fund checks will be charged a $25 fee.

8. The charge for a missed appointment (less than 24 hour notice) is $25 - $50 and will be charged to the patient's accounts. New patients will need to provide us with a credit card at the time of rescheduling another appointment. This credit card will be charged if the second appointment is missed. When you make an appointment, it is your responsibility to attend that appointment. A confirmation call is a courtesy.

9. Medical record requests of more than five pages may be charged following the guidelines set by the Illinois law (Act 92-228).

10. Request for forms to be filled is a non-insurance billed service and must be paid for prior to release of filled forms. The fee is $20-$70.

It is expressly understood that you will be responsible for payment in full of all claims submitted to your insurance company(s) that are not paid within 30 (sixty) days from the date of treatment. If payment cannot be made in full, you agree to contact our billing department and authorize Hinsdale Asthma and Allergy Center, SC to charge your credit/debit card for your balance or to set up monthly payments until your balance has been paid in full.

IF YOUR INSURANCE BENEFITS HAVE BEEN VERIFIED BY OUR OFFICE AND YOU HAVE A REMAINING DEDUCTIBLE AMOUNT, PAYMENT FOR ALL SERVICES RENDERED WILL BE EXPECTED ON THE DAY OF YOUR OFFICE VISIT.

I agree that in the event I default and/or do not make payments in accordance with the terms indicated above, I will be responsible for all costs of collection including attorney fees.

I have read the above and understand that I am ultimately responsible for all charges and authorize my insurance benefits to be paid directly to Hinsdale Allergy & Asthma Center, S.C. and its affiliates (the "Practice"). I also authorize the Practice, the physicians employed by the Practice and my insurance company(ies) to release any information required to process my claim(s). Our office will assist you in working with your insurance company but we cannot be responsible for delays or lack of cooperation/compliance by your insurance company(s) or managed care plan(s). In the case of divorced parents, the parent bringing the child will be deemed responsible for payment and must make arrangements prior to services being rendered.

Signature of Responsible Party or Parties: ____
Date ________________