NORTH SUBURBAN GASTROENTEROLOGY ASSOCIATES, S.C.

Financial Policy Statement

Your clear understanding of our practice financial policies and your patient financial responsibilities is important to our professional relationship. Payment of your bill is considered part of your treatment. Please call our billing department at 847-696-2336 or 708-534-9150 with any questions you may have.

- All patients must fully complete our **Patient Registration Form**
- All patients must provide photo identification card (driver's license, state identification card, etc)
- *If you do not have insurance,* **full payment is expected at the time of each visit**
- We accept cash, check, Visa, MasterCard, American Express and Discover

APPOINTMENT CANCELLATION

All of our patients are important to us. Appointment time is allocated specifically to provide you the utmost in quality care. By providing ***at least 48 hours* appointment cancellation notice,** you allow us to help another patient in need. Repeated cancellations or failed appointments may result in a charge of $25 for office visits and $50 for procedures. Your consideration benefits all.

FILING INSURANCE CLAIMS

In order to file your claim, we must have a copy of the front and back of your insurance Identification Cards with the complete claims filing address as well as owner identification, policy and group numbers. Without this information, you will be billed directly. We file claims for most insurance plans. Balances that remain unpaid may be sent to our collection agency.

We are committed to providing the best treatment possible for all patients and charge what is usual and customary for our area. You are responsible for payment in full, regardless of an insurance company's arbitrary determination of **"usual and customary".**

Managed Care Plans: EPO-HMO-PPO-POS

ALL COPAYMENTS ARE DUE AT TIME OF SERVICE. If you do not know your copayment amount, please call your insurance carrier. In order for your claim to be paid by your carrier, you must provide us with any required referral forms or authorizations prior to your visit. IT IS YOUR RESPONSIBILITY to verify that we are "**in-network**" **with your managed care plan.** *If you are scheduled for a procedure, you must verify that the hospital or facility is "in-network"* to avoid increased deductible and out-of-pocket penalties.

REGARDING *SCREENING BENEFITS*: You must tell us at the time you schedule a procedure if you are scheduling a screening procedure, as hospitals and out-patient facilities bill on the SCHEDULING diagnosis. Please review carefully the "Screening Colonoscopy: Well-Care, Preventative Care, Routine and Screening Notice". Call your insurance carrier to verify the type and amount of screening benefits you may have. Once a claim is billed, we are not allowed to change a diagnosis.

WE ACCEPT regular MEDICARE, RAILROAD MEDICARE – and some MEDICARE REPLACEMENT PLANS

*****IF YOU HAVE A MEDICARE REPLACEMENT PLAN,* you must contact our office prior to your appointment to verify that we are participating providers with that plan!** For regular and Railroad Medicare, you are responsible only for the difference between Medicare's approved amount, the amount they pay and any deductible or co-insurance applied. If you have supplemental insurance, we will bill them directly for you, although they may not cover your deductible, or pay only a portion of your co-insurance due. You will receive a bill after insurance has paid. ***Medicare may require that you sign an "Advanced Beneficiary Notice" (ABN) for some services; we will advise you when and why this may be required.***

LEGAL OR ACCIDENT CLAIMS

If you are here as the result of an accident claim, we require that you provide us with your health insurance information so that we may bill them directly, or that you pay 100% of your charges at the time of service. We also need the name, address and phone number of the accident insurance company and/or your attorney. In case of a lawsuit, we will file a lien with them for the balance. *24 HOUR NOTICE IS REQUIRED FOR COPIES OF MEDICAL RECORDS AND/OR X-RAY REPORTS*; there is a FEE for this service and you must sign our release form.

WORKER'S COMPENSATION

Patients being seen as a result of work-related injuries are still responsible for charges incurred by them. Please notify our office if you have such a claim so that *prior to your visit* we may verify coverage of your charges by your employer. If we cannot verify coverage, you will be responsible for payment of your charges. If your employer does not remit payment for your charges within a reasonable period of time, we will bill you directly.

Signature of Patient or Responsible Party / Date ______________________

NSGA Staff Initials / Date ______________________

PRINT Patient's Name: ______________________

Patient's Date of Birth: ______________________