# North Suburban Family Medicine's Financial Policy

We are committed to providing our North Suburban Family Medicine families with outstanding medical care. We have a dedicated business office staff to address your billing and insurance questions. Our staff is available by phone 847-795-0900 ext 2224 or in person at our office.

It is our goal to make sure you receive the maximum financial benefit from your insurance provider and to make sure that your account is handled in the most efficient manner possible. In order to accomplish this goal it is important that we have your understanding and cooperation in adhering to our financial policies.

**Account Responsibility** - As the patient or parent of a child registered with North Suburban Family Medicine, you are agreeing to be responsible for all balances incurred for your medical care. All balances are due upon receipt of a statement from our office. If you feel your statement is incorrect or you are having financial difficulties, please contact our business office within 14 days. If your insurance company denies your claim or does not pay your claim within 45 days after we have filed the claim, the outstanding balance becomes your responsibility. Please contact us immediately if you are having a dispute with your insurance company or you think your claim has been denied in error.

Initial Here:___________

**Payment for Services** - Payment in full is due at the time of service. We accept cash, checks and most major credit cards as forms of payment. If you are enrolled in an insurance plan in which we participate, we will file your claim for you. Payment is expected in full at the time of service for:

• Copayments and/or insurance deductibles

• If we are not contracted with your insurance company

• If you do not have insurance coverage

• If we are unable to verify your insurance eligibility or we do not have your new insurance information on file

Payment is due within 14 days of receipt of your statement. If your account becomes past due we reserve the right to send you to collections and you will be responsible for all collection and fees that the practice incurs as a result. We reserve the right to refuse to see any patient that has been placed into collection.

**Insurance Coverage** – We are contracted with many insurance companies. We agree to file your claim in the proper manner and to reasonably assist you if there are questions with your claim. It is your responsibility to know and understand your insurance coverage. We will contact your insurance company to verify that you have coverage but we cannot be responsible for contacting them to obtain your benefit coverage.

**Services Rendered** - If you or your child is being seen for a well check up or preventive visit and another condition is treated during the same appointment, we will bill for each service of the services performed.

Initial Here:___________

**Description of Administrative Fees** – Listed below are services for which we charge an administrative fee. These services are not billed to your insurance company and they are your responsibility. Please contact our office for questions about our current administrative fees.

NORTH SUBURBAN
Family Medicine

| Missed Appointment Fees | We have a 24-hour cancellation policy. If you do not cancel within 24 hours of your appointment time you may be assessed a Failed Appointment Fee. |
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| NSF Checks | If your check is not honored by our bank we will assess an NSF processing fee. |
| Health Forms | We assess a fee for filling out health forms outside of a scheduled appointment. |
| Medical Records Request | If you need a complete set of your medical records there is a fee.<br>Copies of your immunization records are provided free of charge. |
| Third Party Medical Records Requests | If a non-medical entity needs a complete copy of your chart, we charge a fee based on Illinois medical record copying laws. If we refer you to a specialist for further treatment we will send a copy of your chart free of charge. |

**PATIENT INFORMATION**

Patient Name______________________________ DOB______________

Person Filling Out This Form______________________________

Relationship to Patient (if applicable): __________________________

I agree to pay for any and all medical services received from North Suburban Family Medicine. I understand that if my insurance company refuses to pay, for whatever reason, these fees will become my responsibility. I understand and agree to abide by the above policies.

______________________________ ______________

Signature Date