Drs. Bell, Stromberg, Harris, Nagle, Wiedrich & Stogin, Ltd.

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to providing the very best care possible. The following is a statement of our financial policy, which we will require you to sign prior to receiving any treatment.

SELF PAY PATIENTS	Full payment is due at the time of service unless a financial arrangement has been made. We accept CASH, PERSONAL CHECKS, VISA, MASTERCARD, DISCOVER, AND AMERICAN EXPRESS.
MEDICARE PATIENTS	We accept assignment for services provided to you, however you are responsible for the 20% unpaid by Medicare plus any "non-covered" charges, such as certain supplies and therapy. Please present your Medicare card and any secondary insurance information so we may submit any coinsurance amount, or you will be responsible for this amount.
MEDICAID (IDPA) PATIENTS	You are responsible for bringing your current Medicaid card. If you are not eligible or determined by the State as having a SPEND DOWN, the payment for services is due at the time of service.
INDEMNITY INSURANCE	Full payment of your initial consult is required at the time of service. Your insurance will be filed for any medical services rendered. This will make certain that any medical expenses will be applied toward your deductible and/or processed by your insurance for payment of your claim. Not all insurance plans pay the same benefits, so there may be a balance due after your insurance has paid your claim. Since the insurance contract is between you and your insurance company, any unpaid balance will be your responsibility. It is important to provide the correct information for filing of any insurance claims. We do all we can to help, but the ultimate responsibility for fulfilling special policy requirements rests with you.
CONTRACTED HMOs	**You must have your referral from your primary doctor before you can see the doctor.** Any co-pay indicated by your plan is due at the time of service. Your plan may require an additional referral for therapy or splinting.
CONTRACTED PPO/POS or other MANAGED CARE (In network)	Any co-pays are due at the time of service. Your plan may require a referral for therapy or splints.
NON-CONTRACTED PPO/POS or OTHER MANAGED CARE (Out of network)	This will be billed as a standard insurance claim. You will be responsible for the balance due.
MOTOR VEHICLE ACCIDENTS	Full payment is due at the time of service. We will bill only <u>your</u> personal auto liability insurance for care rendered to you as a result of an automobile accident. You are responsible for all charges incurred for treatment of you regardless of any claim or legal action pending.
WORKERS' COMPENSATION	We will file a claim with your employer or their insurance company if we have verification that your injury is being considered as a Workers' Compensation claim. You are responsible for any amounts denied under your Workers' Compensation claim.
USUAL AND CUSTOMARY	Our Medical Group is committed to providing the best treatment possible for all our patients, and we charge what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's determination of "Usual and Customary Rates". These are often arbitrary and unrealistic.
STATEMENTS	Statements list any balances due and payment in full is due upon receipt of the statement. If your insurance fails to pay within a reasonable time, payment will be your responsibility.
BAD CHECKS	You will be charged $25.00 for any check returned for insufficient funds.
PAST DUE ACCOUNTS	Seriously past due accounts will be referred to a collection agency. **A collection fee of up to 35% will be added to the balance to recover costs of collection.** In the event that litigation is necessary, you will be liable for court costs and attorney fees as well.

Regardless of any claim pending, if there is an open balance, a statement will be sent to you. If your insurance company refuses or delays payment, or covers only part of the bill, timely payment will be expected from you.

If you have any questions regarding your account please call our billing department (312-337-6960).

I have read and agree to abide by the terms of this financial policy:

____ Date____________________

(Signature of patient or guardian)

____ Chart____________________