NEUROLOGY SPECIALISTS OF NORTHERN ILLINOIS FINANCIAL POLICY

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Thank you for choosing Neurology Specialists of Northern Illinois as your healthcare provider. We are committed to providing our patients with excellent care. The objective of our financial policy is to clearly outline patient and practice financial responsibilities and to make matters related to the payment for health care services as straightforward as possible.

Our staff is happy to help with any questions regarding this financial policy, your account, claims or other questions you may have about your bill. Please understand that insurance reimbursement can be a long and difficult process.
Specific questions about coverage issues can only be addressed by your insurance company. If there is any question regarding coverage, benefits or payment for services provided, it is your responsibility to resolve those issues.

Responsibility for your account ultimately rests with you.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD AND DISCOVER CARDS AS PAYMENT. ANY CO–PAYS OR OUTSTANDING BALANCES WILL BE DUE AT THE TIME OF SERVICE.

******PLEASE NOTE******

NEUROLOGY SPECIALISTS OF NORTHERN ILLINOIS RESERVES THE RIGHT TO CHARGE A $25.00 FEE FOR ANY APPOINTMENT THAT IS CANCELLED OR BROKEN WITH LESS THAN 24 HOURS ADVANCE NOTICE.

Please initial next to your category of insurance listed below, as this will help us to speed up payment and eliminate any confusion in the future.

- ***Self Pay***

______If you are a patient that does not have active coverage with an insurance plan upon appointment, payment will be expected in full at the time of service.

- ***Medicare***

_____ As a participating provider, we accept assignment and will bill your Medicare carrier directly. You are responsible for payment of 20% of the approved amount and your Medicare deductible. Medicare may submit those amounts to your secondary insurance. **If not, we will submit to your secondary insurance once.** However, once Medicare has paid their portion, you are responsible for your 20% of the approved amount and any applied deductible.

- ***Plans in which we are participating providers***

____ ***HMO PLANS***. You are responsible for getting **the proper referral in advance** of your appointment. Without a referral, you will be asked to pay for the visit in full at the time of service and sign a waiver stating you understand we will not bill your insurance for that visit. Alternatively, you may reschedule your appointment giving you time to obtain proper authorization. All co-pays must be satisfied prior to seeing the doctor at each and every visit. There can be no exceptions due to contracting and uniform compliance rules.

_____ ***PPO PLANS.*** We have agreed to accept the discounted rate from your plan, however, all co-insurance is your responsibility. All co-pays must be satisfied prior to seeing the doctor at each and every visit. There can be no exceptions due to contracting and uniform compliance rules.
You will be expected to pay any outstanding balances promptly.

- ***Self Insured/Union Plans***

_____ **Your plan will be billed as a courtesy**. In the event there is a problem collecting from your insurance carrier, you must provide us with the name of your human resources director and/or benefits manager. We may also require your authorization to file complaint letters to the Department of Labor and your administrator if necessary. In the event your plan has not reimbursed us within 45 days, you will be responsible for payment in full.

- ***Non contracted or Indemnity Insurance Plans/Public Aid***

____ **We will bill your insurance as a courtesy and convenience to you.** You may dispute the insurance payment directly with your insurer. However, you are ultimately responsible for payment in full for medical services provided to you. If you have Public Aid, you MUST present your current coverage card, or you will be responsible for the balance in full at the time of service

- ***Workers compensation or Motor Vehicle Accidents***

_____ **WORKERS COMPENSATION** We will bill the appropriate insurance company for these claims, however, it is your responsibility to provide us with the claim number, address of the worker's comp carrier and any other pertinent information required by us to submit charges for payment. Refusal to provide any and all required information to us makes you directly responsible for payment for services rendered. Collection activity will be initiated if required.

_____ **MOTOR VEHICLE ACCIDENTS** We will bill the appropriate insurance company for these claims as a courtesy, however, it is your responsibility to provide us with the claim number, address of the insurance carrier and other pertinent information required by us to submit charges for payment. Any remaining balance after insurance payment is your responsibility.
We are not subject to claims in litigation in the courts. Any claims pending the outcome of litigation must be paid at the time of service.

Additional Information

Secondary Insurers: Having more than one insurer does NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We will submit to your secondary insurance **once**. If we do not receive payment within 40 days, it is your responsibility to pay any outstanding balance. You can then continue to pursue reimbursement from the secondary insurer.
Usual & Customary Rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates.
Divorce Decrees: This office is not a party to your divorce decree. Adult patients are responsible for their bill. The responsibility for minors rests with the accompanying adult.

I have read the Financial Policy. I understand and agree with this Financial Policy.

X________________________________ ______________________
Signature of Patient or Responsible Party **Date**

X________________________________ ______________________
Signature of Witness **Date**