

## **ORTHOPAEDIC CENTER OF ILLINOIS, LTD. AND OPEN MRI OF ILLINOIS FINANCIAL POLICY**

The following statement is our Financial Policy. It is required that the patient and/or responsible party (hereinafter referred to as “you”) read and sign this statement prior to any treatment. All parties must also complete and sign our Information and Insurance form prior to treatment

### **SELF PAY**

A \$125.00 payment is due prior to treatment from all uninsured patients. You will have 60 days to pay your account balance in full.

### ***WE ACCEPT CASH, CHECKS, VISA OR MASTERCARD***

### **INSURANCE**

We reserve the right to accept or deny assignment of insurance benefits. If we accept assignment of benefits it is your responsibility to supply our office with a copy of your current insurance card. Please remember that your insurance policy is a contract between you and your insurance company. The balance on your account is your responsibility. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, you will be expected to pay your balance. Please keep in mind that some, and perhaps all, of the services provided may be non-covered services. Also be aware that some services may not be considered reasonable and/or necessary the Medicare Program or other medical insurance.

Regarding insurance plans where we are participating providers, all co-pays and deductibles are due at time of service. In the event that your insurance coverage changes to a plan where we do not participate, please refer to the information in the above paragraph.

### **USUAL AND CUSTOMARY**

Any reduction of payment or denial of payment by your insurance company due to “usual and customary rates” is your responsibility to pay. Our charges are based on the usual and customary rates for our area. They are not based on the determination of any insurance company.

### **WORKER’S COMPENSATION**

Your employer must complete and sign an “Employer’s Worker’s Compensation Claim Acknowledgment” form. It is your responsibility to bring this completed form with you along with all billing information for your account (carrier name and address, contact person, telephone number and claim number if applicable). This information must be provided to us prior to treatment. If your account is not paid in full within 60 days you are responsible and will be expected to pay your unpaid balance. The Orthopaedic Center of Illinois will not accept a delay in payment due to a worker’s compensation dispute and/or litigation. We may accept assignment of your health insurance benefits.

### **LIABILITY INJURY**

If you are being seen due to a liability injury you must provide the following information for billing and verification of payment prior to treatment:

\*Auto Accident: if you were injured in your own car you must provide us with the name and address or your auto insurance company, your agent/adjuster’s name, telephone number, your claim number and date of accident.

If your injury occurred in someone else’s car, we require all of the above information and the following, their name, the name and address of their auto insurance company, their agent/adjuster’s name, telephone number and their claim number.

In addition to the above we require the name of the person at fault, the name and address of their auto insurance company, their agent/adjuster's name, telephone number and their claim number.

\*Slip and fall, etc.: if you were injured on residential property or in a residential dwelling, we require the following, homeowner's name, the name and address of their homeowner's insurance company, their agent/adjuster's name, telephone number, their claim number and date of accident. If your injury occurred at a place of business, please provide the same information; i.e. business name, business insurance company, etc.).

If your account is not paid in full within 60 days, you are responsible and will be expected to pay your unpaid balance. The Orthopaedic Center of Illinois will not accept a delay in payment due to settlement disputes and/or litigation. We may accept assignment of your health insurance benefits.

### **MINOR PATIENTS**

The following parties are responsible for payment of the minor's account balance: the adult accompanying the minor and the parents (or guardians of the minor). A minor that is not accompanied by an adult will be denied any non-emergency treatment unless charges for the treatment have been pre-authorized.

### **ASSIGNMENT OF BENEFITS AND RELEASE OF RECORDS**

You do hereby assign to the Orthopaedic Center of Illinois, Ltd., the medical benefits to which you , or your dependents are entitled. You also authorize the Orthopaedic Center of Illinois, Ltd., to furnish to your health insurance company all your patient information including but not limited to any and all medical records, notes, test results, x-ray reports, MRI reports or other documents related to your treatment (including itemization of any charges and payments on your account) that is deemed necessary to process this claim. You also authorize the Orthopaedic Center of Illinois, Ltd., to release any and all patient information and medical records necessary to collect this debt.

### **“NO SHOW” APPOINTMENTS**

If you are unable to keep your scheduled appointment please be courteous by canceling at least 24 hours in advance.

### **FINANCE CHARGES AND RETURN CHECK FEES**

You agree to pay a finance charge at the rate of 1 ½% per month (18% per year) on all unpaid balances commencing 60 days from the date of service. You also agree to pay a \$20.00 service charge on all return checks.

### **COLLECTION COSTS AND PROCEDURES**

If your account becomes delinquent, you agree to pay any additional charges to collect your unpaid bills, including but not limited to, reasonable attorney fees, court costs and collection agency fees. By signing this policy you do acknowledge that we reserve the right to release any patient information and any medical records to our collection agency deemed necessary to assist their staff and their attorneys in the collection of this debt.

By signing below you do affirm that you read and understood our Financial Policy and that you agree to its contents.

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Signature of patient or responsible party

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Date