Patient ID:_____

PAIN SPECIALISTS OF GREATER CHICAGO

Scott Edward Glaser, M.D., D.A.B.I.P.P.
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FINANCIAL PAYMENT POLICY

Given the constant changes to insurance company payment policies, the following in-office policies have been established to help us continue to provide the patient with the best quality of medical care. These policies are intended to assist the patient in receiving care and for greater understanding in all aspects of patient care. If you would like to discuss the office fee schedule, or these office policies, please ask to speak with a member of our Billing Department.

PAYMENT IS DUE AT THE TIME OF SERVICE.
This includes co-pays, deductibles, co-insurance and non-covered charges.

a) **Co-pay must be paid at the time of visit**.
b) For the patient's convenience, the office accepts cash, Visa, Master Card, Discover, and American Express **NO CHECKS ACCEPTED**
c) The patient is responsible for all **NON-COVERED** SERVICE CHARGES

SELF PAY : **Patients must pay for visit and any balance in full at time of appointment.**

ANY CHANGES to your DEMOGRAPHICS or INSURANCE must be brought to our attention**, BEFORE** the Doctor's visit.
Failure to do so may result in the patient being **responsible in FULL for ANY & ALL charges** for services rendered. The **CORRECT** information is **CRITICAL** especially for proper billing of laboratory test that may be required and ordered. If this information is incorrect or not current the patient will be responsible for the bill in its entirety.

HMO, PPO, POS or other Health Plan ID cards must be current.

If you have medical insurance, as a courtesy to you we will try to speed up the processing of your claim by electronically submitting to your insurance company. However, your insurance is a contract between you and your insurance company. Our office **CANNOT** guarantee that your carrier will pay your claim**. If your claim is denied by your carrier, the obligation for payment is the responsibility of the patient**. Our office will **not** enter into a dispute with the insurance carrier over the claim. We will however, be happy to assist wherever possible. If the patients' bill remains overdue the following procedure will occur.

- Any outstanding balance will become **Zero balance status** and **cannot** carry a balance.
- All outstanding bills must be settled **prior** to receiving future care, unless **PRIOR** arrangements have been made.

AUTHORIZATION
Until further notice, I authorize Pain Specialist of Greater Chicago to charge the patient-responsible balances on my account to the following credit card/debit card .

Circle One: VISA MasterCard Discover Amex

Name on Credit Card: _____

Credit Card Number: _____

Three Digits on Back of Credit Card: _____**Phone#**_____

Exp. Date (mm/yy): _____

Credit Card Billing Address: Street Number: _____ **Zip Code**: _____

Patient Name: (if different from above): _____

I understand that once the insurance has paid their portion for my care. I will receive an Explanation of Benefits (EOB). The insurance plan EOB will state any balance remaining to-be-paid by me. I agree that Pain Specialist of Greater Chicago may charge my credit/debit card the balance due when they receive a copy of the EOB. I also understand that Pain Specialist of Greater Chicago may charge my credit/debit card for any open balances due as well, if they determine a prior balance exist.

Cancellations/Missed appointments - Failure to keep your appointment or failure to cancel your appointment within a **24 hour** notice to fill the time slot we have reserved for you will result in a penalty charge of $35.00, except in the case of a Procedure the charge will be $100.00. This fee is **NOT** covered by insurance and is the sole responsibility of the patient. You the patient will be billed accordingly. Please have the courtesy and respect to call our office for all appointments that cannot be kept.
We work with you at every opportunity to provide you with the best quality health care.

I have read and understand the payment policy and agree to abide by its guidelines:

Print Name: _____

Signature: _____ **Date:** _____

Verified by : PSGC Employee name: _____**Date:**_____