



PAIN SPECIALISTS OF GREATER CHICAGO

Patient ID: _____

BENEFIT ASSIGNMENT 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 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
- d) **SELF PAY** patients must pay at time of visit-
ESTABLISHED PATIENT-Subsequent visit fees-\$100.00, Lab Test Fees-\$127.00 Expected at next appointment
NEW PATIENT-\$274.00 This includes the office visit fee of \$147.00 and Lab Test Fee of \$127.00.

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 tests 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.

Health Insurance/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 submitting claims to your insurance company. However, your insurance plan 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 greater than 90 days the following procedure will occur.

- Any outstanding balance after 90 days of the date of service 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.

Precertification for Procedures: Benefits verification/ Authorization contains general reimbursement information based on medical necessity and is not a guarantee of payment by my insurance company and is provided to me by PSGC- By signing this form, I am fully responsible for any balance due to non-payment by my insurance company.

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 **\$50.00**, for an office visit and **\$150.00** for procedures These fees are **NOT** covered by insurance and is the sole responsibility of the patient. You the patient will be billed and payment is expected before next appointment. 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: _____ Date: _____

Signature: _____

Verified By PSGC Employee Name: _____ Date: _____