

## SELF- PAY FINANCIAL PAYMENT POLICY PAYMENT IS DUE AT THE TIME OF SERVICE

PATIENT ID#	
The self-pay policy has been established to help us capuality of medical care. This policy is intended to assure reasonable and specific to services provided. By Pain Specialists of Greater Chicago, you will be re MRI/CT/X-ray /other LAB tests (including screening Greater Chicago.	sist patients in receiving care at fees that electing to be self-pay for services from sponsible to pay for office visits and/or
<ul> <li>Patients must pay for visit and <u>any balance</u> in appointment will be rescheduled. Balance exp appointment date.</li> </ul>	<del>-</del> -
• Pre-payment will be <u>required before</u> any in-of scheduled.	fice or outpatient surgical procedure is
<ul> <li>Ambulatory Surgical Centers are <u>separate ent</u> patient payment criteria. The Ambulatory Sur fees. Any payment arrangements made are ent</li> </ul>	gical Center will contact you regarding
FEE SCHEDUL  NEW PATIENT - \$274.00 expected at time of appointment and lab test fee of \$127.00	
ESTABLISHED PATIENT-	
Subsequent visit fees - \$100 .00 Expected at time of appoin	tment
Lab Test fees - \$127.00 Expected at next appointm	
<u>Cancellations/Missed appointments</u> - Failure to keep your	appointment or failure to cancel your
appointment within a <u>24 hour</u> notice to fill the time slot we penalty charge of \$ <u>50.00</u> , except in the case of a Procedure	
I have read and understand the payment policy and agree questions I may have about this form have been answered	
PATIENT NAME	
PATIENT SIGNATURE	DATE:

PAIN SPECIALISTS OF GREATER CHICAGO

\_DATE:\_\_

VERIFIED BY PSGC EMPLOYEE (NAME) \_\_\_