Suburban Surgical Associates, Ltd.
Suburban Metabolic Institute, LLC

3340 S. Oak Park Ave., Ste. #309
Berwyn, IL 60402
P#: 708-484-0621 F#:708-484-0250

5201 Willow Springs Road, Ste. 180
LaGrange, IL 60525
P#: 630-325-5070

PATIENT NAME: _____ DATE: _____
(PLEASE PRINT NAME)

******PLEASE READ EACH SECTION AND INITIAL EVEN IF THE SECTION DOES NOT APPLY. THIS IS SIMPLY VERIFYING THAT YOU HAVE READ ALL OF OFFICE POLCIES AND PROCEDURES. THANK YOU!!*******

PATIENT OFFICE POLICIES AND PROCEDURES

REFERRALS

If you have an insurance plan that requires you to have a referral to be seen in our office, it is your responsibility to obtain a referral from your primary care physician/specialist to ensure our office has a current copy. _____initial

CO-PAYS/CO-INSURANCE/DEDUCTIBLES

As required by your insurance plan, **all co-payments are due at the time of service**. Co-pays, co-insurance, deductibles and non-covered services cannot be waived by our office as it is an insurance requirement. Our office does not bill for co-pays. We accept **CASH, VISA**, **MASTERCARD, DISCOVER, and AMERICAN EXPRESS.** However, this office will not process any charge under $10.00. **CHECKS ARE NO LONGER ACCEPTED.**
If a patient is not prepared to pay the co-pay, the clinical staff will determine if it is medically necessary for the patient to see the physician. If the patient's condition allows, the appointment will be rescheduled. **_____initial**

INSURANCE LIABILITY AND COORDINATION OF BENEFITS

When making an appointment with one of our physicians, it is the ***patient's responsibility to confirm with our office and the insurance company that the physician is currently under contract with your plan***. As a service to you, we will bill the primary and secondary insurance companies. While providing this service, it is extremely difficult for us, and our Doctors, to be aware of the multitude of individual requirements for each of these plans. Each plan has its own stipulations regarding the coverage of, and payment for, medical services. Therefore, it is your responsibility to know your plan's benefit policies. (Example: Co-pay must be paid the day of your visit, if your company covers 80% of the claim and you are responsible for 20% of the claim, payment will be expected for your portion). **If you have a secondary insurance it is the responsibility of the patient to coordinate their benefits and inform this office.** If so, you must advise the front desk. This will prevent being billed for services not covered due to the lack of proper coordination and authorization of services rendered.

Please be aware not all services are covered by all insurance payers. _____initial

MEDICARE PATIENTS

We are participating providers with Medicare Part B. This means that we accept assignment for all services provided to our Medicare patients. Medicare pays 80% of the allowed amount once your deductible has been met. Medicare B patients will be responsible for the remaining 20% co-insurance in addition to any unmet portion of the annual Medicare Part B deductible ($183.00 for 2018). We are contracted with many of new

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Medicare PPO, POS and HMO plans; however it is the patient's responsibility to obtain the proper referral authorization. _____**initial**

INSURANCE AND ID CARDS

Insurance cards and ID cards must be CURRENT and are required at each visit. This will prevent fraudulent use of your health care benefits. It is important not only for your **MEDICAL SAFETY**, but for the protection of your identity, that your **LEGAL NAME MUST APPEAR** on your insurance card and ID.

If there are any changes to your insurance including, but not limited to, new insurance identification number and/or group number it is the responsibility of the patient to inform this office immediately. **If the patient does not provide this office with accurate insurance information (i.e. change of insurance company or you are now on a COBRA PLAN), the patient will be fully responsible for any balances due, due to denied insurance payments**. ***Our relationship is with YOU, not your insurance provider.*** _____**initial**

We allow 30 days for your insurance company to respond on a claim and 60 days for them to process and/or issue payment. If your insurance company does not respond or pay your claim within 60 days, the full balance will become the patient/guarantor's responsibility. _____**initial**

I understand that I am responsible and liable for payment of all charges assessed for professional services rendered. I understand that I am primarily responsible for all charges regardless of my existing medical coverage. In the event my insurance company forwards payment directly to me, I will deliver such payment to Suburban Surgical Associates, Ltd. /Suburban Metabolic Institute, LLC. I understand that I am responsible for meeting my insurance deductible and co-insurance for any non-covered services. In the event my account is sent to a collection agency, I understand I will be responsible for any additional assessed collection fees, to include any attorney fees assessed to recoup the outstanding balances. I understand the financial policy as detailed above. _____**initial**

SELF-PAY PATIENTS – (NO INSURANCE COVERAGE)

If you do not have valid health care coverage, payment for the day's charges is expected at the time of service. If you are unable to pay for your consultation, you may be asked to reschedule your appointment. An initial payment of $250.00 is required at your initial consultation. You will then be balance billed for any additional charges. _____**initial**

Patients requesting a discount for medical services rendered through SSA or SMI must present the prior years tax filing, proving annual income status for consideration. _____**initial**

PROCEDURE DEDUCTIBLES

Almost all insurance plans now have patient out-of-pocket deductibles that must be met. Our pre-authorization staff will contact you with any deductible balance; this must be paid prior to the scheduled date of your procedure. This is payable by phone via **CREDIT CARD** or you may stop in the office to pay **CASH, OR A BANK MONEY ORDER.** _____**initial**

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(PLEASE PRINT NAME)

LATE FOR APPOINTMENTS

Please make every effort to notify our office if you will be arriving late to your appointment. If you will be more than **15 minutes** late we may need to reschedule your appointment or we may ask that you wait until the next open appointment spot on the schedule while we continue to see the patients who have arrived on time. _____**initial**

MISSED OR NOT SHOWING FOR YOUR SCHEDULED APPOINTMENT

Occasionally patients are faced with emergencies or unavoidable circumstances that may interfere with a previously arranged appointment. We ask that 24 hour notice is given when canceling an appointment. ***"No showing"*** for an appointment will result in a **$25.00 fee for an office visit and $100.00 for a scheduled in - office procedure,** which is not covered by insurance. **Multiple missed appointments could result in being dismissed from the practice**. _____**initial**

WORKER'S COMPENSATION and MOTOR VEHICLE ACCIDENTS

It is the responsibility of the patient to advise this office if their injury is work related. You must provide this office with your employer's name, address, phone number. Additionally, you will provide this office with the worker's compensation insurance carrier's name, phone number, and claim number. **If your injury is work related and you do not provide our office staff with accurate billing information, any charges will become the responsibility of the patient.** Patients **involved in a motor vehicle accident** are responsible for presenting their individual group health insurance information. The patient will be responsible for submitting all claims to the responsible party's insurance. This office does not submit third party insurance claims. _____**initial**

DIAGNOSIS CODES

This office cannot recode an office visit or a procedure because your insurance does not cover a certain visit; this is illegal and considered fraud. It is the responsibility of the patient to know what your insurance company plan covers (e.g. colonoscopies, mole or skin tag removal). _____**initial**

OUSTANDING BALANCES

When contacting this office to schedule an appointment, please be aware that if your account is in collections for services previously provided, your account must be paid in full before your next visit. If your account is not brought up to date, your appointment will be not be made or cancelled. _____**initial**

BILLING STATEMENTS

This office sends out monthly billing statements to all patients. The balance due is a remainder owed after your insurance company has paid their portion. It is the responsibility of the patient to keep his/her account current even if you are disputing a claim with your insurance company.

In event you do not receive a statement any monies owed will also be listed on the E.O.B/Explanation of benefits that you will receive from your insurance company. Look for the statement **"YOU MAY OWE THE PROVIDER"** with an assigned dollar amount. It is the responsibility of the patient to pay any and all outstanding balances to this office.

If you change your mailing address or last name this too is the responsibility of the patient to inform this office to insure all office correspondence is received by you the patient. _____**initial**

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PAYMENT PLANS

If you have negotiated a payment plan with our billing office, it is the patient's responsibility for making timely and consistent payments. We offer payment plans as a courtesy to our patients in time of need. If you fail to make your scheduled payment and do not contact our billing office prior to your scheduled payment date, your account will be sent to collections for non-payment. **_____initial**

UNCOOPERATIVE PATIENTS

Physicians are not required to continue treatment of a patient who is uncooperative, refuses to follow treatment advice and/or presents difficulties in the doctor-patient relationship. Our goal is to try to accommodate all of our patients' needs. Demanding and abusive language does not help us achieve that goal. Patients may be dismissed from our practice for non-compliance. **_____initial**

FMLA PAPERWORK/SHORT TERM DISABILITY FORMS

If your employer requires FMLA (Family and Medical Leave Act) **OR** if you have Short Term Disability packet(s) that needs to be completed by your physician, please allow 7-10 business days for completion. A minimum $15.00 fee is assessed for each packet completed. **_____initial**

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

10/23/2018