Last Name: First Name:

PRINT

DOB:

SOUTHWEST GASTROENTEROLOGY / OAK LAWN ENDOSCOPY
FINANCIAL AGREEMENT

*** PLEASE READ THIS FORM AND SIGN – NO OTHER INFORMATION IS REQUIRED ***

Our office is committed to providing you the best possible medical care, and to working with you to help avoid financial barriers to your care. This sheet is designed to explain your financial responsibility, and our responsibility to bill your insurance.

As a courtesy, we will bill your insurance plan directly so that you do not have to pay your bill in full at the time of service. You will need to pay at the time of service:

1. **Office Copayment**
2. **Coinsurance** (if no copay, usually a percentage % of charges)
3. **Old balances determined to be your financial responsibility**

It is important that you understand the rules of your insurance in order to receive the greatest level of benefits. Below is a general guide to the most common types of insurance plans for your review. Please review and then check your specific insurance plan rules to determine the proper procedures under your plan.

Commercial insurance, also known as indemnity, or 80/20% coverage:	This type of plan usually divides your financial responsibility into a percentage. For example, if you have an 80/20 indemnity plan, your coinsurance is 20% of the charges which is due at the time of service. If you have a 70/30 plan, your coinsurance is 30% of charges.
Preferred Provider Organization (PPO) plan:	This type of plan requires that you seek care from an in-network provider. It is your responsibility to ensure you choose an in-network provider for services. If our physicians are not in the network, payment is due, in full, at the time of service.
Point of Service (POS) plans:	This plan requires that you obtain a referral form from your primary care physician (PCP) for each visit and/or procedure in order to receive the best benefits. However, a POS plan allows you to go out-of-network, but your copay, coinsurance, and/or deductible may be significantly increased if you do not obtain a referral.
Health Maintenance Organization (HMO) plans:	This plan requires that you obtain a referral form from your PCP for each visit and/or procedure. If you do not provide a referral form, payment is due at the time of service.
Medicare	This is a federal plan. We accept Medicare assignment and bill Medicare as a participating provider. Your co-insurance of 20% of the allowable charge and unmet deductible is due at the time of your visits unless you have an approved Medigap secondary insurance. Payment for non-covered services is due at the time of service.
Medicaid (Public Aid)	This is a state plan. A copy of the Medicaid eligibility card needs to be provided at each visit. Payment for non-covered services is due at the time of service.
Uninsured	Payment is due at the time of service. We will help you set up a payment plan if necessary.

SOUTHWEST GASTROENTEROLOGY / OAK LAWN ENDOSCOPY
FINANCIAL AGREEMENT (CONTINUED)

SIGNATURE PAGE

In accepting services you, the undersigned, hereby agree to the following statements:

1. I agree that I am financially responsible for my account. I understand that my insurance is billed as a courtesy to me, and is not intended to relinquish my financial responsibility.

2. I agree to pay copayments, coinsurance, deductibles, and any remaining balances at the time of service that are deemed to be my financial responsibility.

3. I agree to pay any amounts billed to me on a statement within 10 days of receiving the statement.

4. I agree to pay a $25 service charge for checks returned for insufficient funds.

5. I agree to pay collection costs for unpaid balances referred to a collection agency, and attorney fees and court costs should the unpaid balances be referred to an attorney for litigation.

6. I agree to pay $15 for any cancellations made with less than one business days notice.

I certify that the insurance information I provided is correct, and that I will notify your office of any changes in insurance. I also certify that I have read and understand the two-page financial agreement.

Signature of Patient: _____ Date: _____

Printed Name: _____ DOB: