



Specialty Care Institute

& THE HEARING INSTITUTE

PATIENT FINANCIAL POLICY

Patient Name: _____ **DOB:** _____

Thank you for choosing Dr. Alvi for your medical care. We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship.

We sincerely hope that by sharing our financial expectations we will strengthen the practice-patient relationship and keep the lines of communication open. This financial policy helps the practice provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact our office manager at 847-277-0111.

Payment is Due At the Time of Service

- We accept cash, checks, debit, and credit cards.
- All co-payments, deductibles and non-covered services are due at the time of service unless you have made payment arrangements in advance of your appointment.
- Insurance required co-payments are due when you check in for your appointment. If you arrive without your co-payment, we may ask you to reschedule. We charge an administration fee of \$25.00 for co-payments not paid at the time of check in.
- If your co-payment is based on a percentage (example: 20% of the allowed payment) and you do not have a secondary policy, please be prepared to pay a minimum of \$40.00 on the date of service.
- Patient-responsible balances are due when you check in for your appointment.
- In the event you need surgery and you do not have health insurance coverage, we must receive down payment of no less than 50% of the estimated doctor's fees before we will schedule the surgery. The payment is expected in full prior to the date of surgery.
- We request that at least **24 hour** advance notice be given to the office if you will be unable to keep your scheduled appointment. All cancellations with less than 24 hours notice and no-shows will be billed \$35.00 per occurrence. Patients will be expected to pay the \$35.00 fee prior to, or at the time of their next appointment. If we need to bill you, the \$25.00 administrative fee will be applied in addition to the cancellation/no-show fee. Patients who repeatedly "no show" for appointments may be discharged from the practice.
- There is a \$25.00 fee for checks returned non-sufficient funds

Proof of Insurance

- Please bring your insurance card(s) and a valid photo ID with you to each appointment.
- It is your responsibility to notify the practice of changes in your health insurance.

Self Pay

- We designate accounts, **Self-Pay**, under the following circumstances: (1) patient is covered by an insurance plan that our physicians do not participate in, (2) patient does not have a current, valid insurance card on file, (3) patient does not have a valid insurance referral on file, or (4) patient does not have health insurance coverage.

Referrals

- If you have an HMO plan we are contracted with, you need a referral authorization from your primary care physician. It is your responsibility to call our office 24-48 hours prior to your appointment to see if we have received your referral. If we have not received an authorization prior to your arrival at the office, call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled or asked to pay for the visit in advance.

Our Responsibility to Report Non-Compliance

- It is our obligation under many of the insurance contracts to report patients who: repeatedly refuse to pay co-payments/deductibles at time of service, or who repeatedly “no show” for appointments.

Divorce and Child Custody Cases

- In cases of divorce, the individual who receives care is responsible for payment of co-payments, coinsurance, deductibles, and nonparticipating insurance balances at the time of service. We will not bill a divorced spouse for the patient’s services.
- The parent who brings the child to the office for care is responsible for payment at the time of service no matter if the account is self-pay, participating insurance, or nonparticipating insurance. The practice does not honor divorce specifics (*e.g., percentage of financial responsibility*).
- If the child has coverage with a participating insurance plan and the proper insurance identification is present at the time of service, the practice will bill that insurance company. Applicable co-payments, coinsurance and/or deductibles are due at the time of service, unless arrangements have been made with the office prior to arrival.

Billing, Payments and Refunds

- All balances are due in full within 14 days of the statement date.
- If you cannot pay the balance in full with 14 days, please contact our billing department to see if you qualify for special payment options.
- It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage.
- If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same guarantor or financial responsible party.
- We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, or terminate you as a patient of this practice.

PLEASE INITIAL BELOW

_____ I have read, understand, and agree to the above **Financial Policy**. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

_____ I authorize my insurance benefits be paid directly to name of your practice.

_____ I authorize Dr. Alvi, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

_____ I authorize Dr. Alvi to release to appropriate agencies, any information acquired in the course of my or the above named patient’s examination and treatment.

X Patient/Guarantor Signature _____ Date _____

