SOUTHWEST PHYSICIANS GROUP
4861 West 95th Street
Oak Lawn, Illinois 60453
Telephone: (708)423-2880

Financial Policy

Welcome to Southwest Physicians Group.

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this financial policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

You will be asked to show the receptionist your current insurance card at each visit. Please come prepared. This allows our staff to verify the information and assist you in collecting the benefits from your insurance company to which you are entitled.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Self Pay.** If you do not have insurance or are seeking care outside of your insurance plan benefits, payment in full is required prior to being seen by the physician. Our associates will provide you with an estimate of your visit prior to your appointment. For your convenience, we accept Visa, MasterCard or Discover cards.
3. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. If you are not prepared to pay your co-pay, your appointment will be rescheduled.
4. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
5. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license, current valid insurance card and your social security number, in order to confirm proof of insurance and file your claim. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
6. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

   If we do not hear from your insurance company:

   If we have not received payment or rejection from your insurance company, in a timely manner, we will transfer the balance to your responsibility. We request that you follow up with your insurance company to resolve any non-payment issue.
7. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
8. **Nonpayment.** If your account becomes delinquent, you agree to pay any charges to collect your unpaid bills, including but not limited to, reasonable court costs, and/or collection agency fees. After you have received two statements, your account is considered past due. At that time, you will receive a letter stating that you now have 10 days to pay your account in full. Payment plans may not exceed a six month time period, unless otherwise

negotiated. You must contact us for a reasonable payment arrangement or risk collection action. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency or a collection attorney. Patient accounts that have been placed with a collection agency are considered to be a breach of the patient-physician relationship and, for this reason, the patient may be discharged from the practice.

For Accounts that have been forwarded to the collection agency, please contact the agency at:

Collection Professionals Inc.
1256 West Jefferson
P.O. Box 841
Joliet, Illinois 60434-0841
Telephone: 800-383-0024

9. **Missed appointments.** Our policy is to charge for missed appointments not canceled within **24 hours** prior to your appointment. You will be charged for a normal office visit fee. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
10. **Returned Checks.** A fee of $25.00 for checks returned to us for insufficient funds will be charged to your account. Future services will require payment by cash, money order or credit card for your payment obligations.
11. **Balances.** All balances must be paid in full prior to being seen by a physician. Failure to make this payment may result in your appointment being rescheduled.
12. **FEES.**

    Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. We suggest you contact your insurance carrier, prior to services being rendered, so that you are aware of your potential financial responsibility.

    Health plan coverage varies significantly by carrier, by employer and/or by contract. As much as we try, we do not always remember the benefits and exclusions for each of our patient's health plan. It is the responsibility of the patient to know and understand his/her plan's coverage benefits.

13. **Disability and other forms.** Our rates for completing the following forms is due prior to completion and a medical release form must be signed:
    - FMLA - $35.00
    - Disability/Physician Attestation - $25.00
    - Miscellaneous Forms - $25.00
      (Please allow 2 – 3 weeks for the forms to be completed.)

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

____ ________/___________/_________________

(Print Patient's Name) *(Patient's Date of Birth)*

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(Print Name of patient or responsible party)

____ ________/___________/_________________

(Signature of patient or responsible party) *(Date of signature)*