Western Springs Asthma & Allergy. S.C.
5600 S. Wolf Road, Suite 135
Western Springs, IL 60558
(708) 246 - 4515

OFFICE POLICIES & FINANCIAL CONSENT

**** *Please read this carefully and completely*****

- For PPO's, HMO's and Medicare I give my permission for my insurance company to be billed and for payment to be made directly to my physician.
- **HMO Patients**: prior authorization is required prior to each service, and must be presented at the time of service. **Obtaining a valid referral is the responsibility of the patient or guardian**.
- Co-payments*are due at the **time of the visit**. If a co-payment is not provided the office reserves the right to reschedule my appointment. *(if applicable)
- Until deductibles are met, all services will be paid in full regardless of type of insurance.
- You are responsible for all balances due once your insurance company has responded to the bill. All payments not received by the statement due date will be considered delinquent and appropriate collection action will be taken.
- If not covered by insurance, payment is required on the date services are rendered. [Arrangements to accommodate financial needs can be discussed.]
- Our office accepts cash, checks and VISA/Mastercard.

Please **"X"** the following once you have read them:

[ ] There will be a **$10.00 late fee** assessed **monthly** to accounts that are past due.

[ ] There will be a **$35.00 charge** for no-shows for returning patients. Not showing up affects not only you and the physician, but also someone else who could have had the appointment time. Please note this is not covered by insurance and is your responsibility.

[ ] There will be a **$65.00 charge** for a new patient appointment no-show.
Be courteous to other patients and cancel within two (2) business days.
Please note this is not covered by insurance and is your responsibility.

[ ] There will be a **$20.00** charge for rewritten, faxed and/or phoned prescriptions already given.

[ ] **Three (3) No-Show** appointments may result in patient termination from the practice.

I have read and understand this policy.

_____
Patient name

_____ _____
Signature of patient or guardian Date