Suburban Surgical Associates, Ltd.
Suburban Metabolic Institute, LLC
3340 S. Oak Park Ave., Ste. 309
Berwyn, Il 60402
Phone: 708-484-0621 Fax: 708-484-0250

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

CO-PAYS

Co-Pays are due at the time of service. 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. _____initial

Insurance:

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 all 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 your plan requires a referral prior to seeing a specialist, please contact your primary care physician and bring the referral with you to your appointment**. Failure to bring the necessary referral will cause your appointment to be rescheduled. 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.

INSURANCE CARDS

Insurance cards are required at every visit. 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 to provide this office with accurate insurance information, the patient will be responsible for any balance due. _____initial

SELF-PAY PATIENTS' – (NO INSURANCE COVERAGE)

An initial payment of $250.00 is required at the time of service. You will then be balance billed for any additional charges. _____initial

Patient Name:_____
(Please print name)

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 by any of the methods listed above. _____initials

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 you choose to submit a work related claim to your group health insurance, and the claim is denied, the full balance will become the patient's responsibility.

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 parties insurance. This office does not submit third party insurances claims. _____initials

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 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 canceled. _____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. It is the responsibility of the patient to keep his/her account current even if you are disputing a claim with your insurance company. _____initial

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.

Patient Name: _____

(Please print name)

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 on any non-covered services. In the event my account is sent to a collection agency I will be responsible for an additional 20% assessed collection fee. I understand the financial policy detailed above. _____initial

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 coincide with a previously arranged appointment. We ask that 24 hour notice is given when canceling an appointment. No showing for an appointment could result in a $20.00 fee which is not covered by insurance. Multiple missed appointments could result in being dismissed from the practice. _____initial

UNCOOPERATIVE PATIENTS

Physicians are not required to continue treatment of a patient who is uncooperative, refuse 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 a Short Term Disability packet(s) that needs to be completed by your physician, please allow 7-10 business days for completion. A $15.00 fee is assessed for each packet completed. _____initial