2015

Willow Oak Pediatrics
Statement of Patient Financial Responsibility

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy or your responsibility regarding these issues.

ALL PATIENTS must complete the Patient Information and Consent to Treat Forms before seeing the doctor.

If you have insurance, we will help you receive maximum benefits. We will file claims on Office visits as long as we have a **CURRENT INSURANCE CARD** with all necessary information. Ask the receptionist if you need a receipt for you visit. If you owe a CO-PAY, it is due to the receptionist when you check in.

Insurance is a contract between you and your insurance company. We are not involved with the contract in most cases (except for the insurance networks). When we file claims, we do it as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductions, co-payments, non-covered charges, secondary insurance, “unusual and customary” charges, etc. other than to supply factual information as necessary. You are responsible for the timely payments of your accounts. If payment is not received from your insurance within 45 days, we have the right to bill you directly. It is your responsibility to pay any deductibles, co-pays or co-insurances upon the completion of processing your claim.

Medicaid (IL Health Connect, IL Public AID, ALL Kids)
It is your responsibility to call the IL Public Aid Department to have your child added to one of our Doctors panels. If you are seen in this office and are not on our panel, you will be financially responsible for the office charges and any charges related to that visit.
We do not accept IL Medicaid (IL Health Connect, Public Aid or ALL Kids) as a secondary insurance.

Initial________

Cancellation/No Show Policy
We understand there may be times when you will need to cancel an appointment. However, you must call the office at least 24 hours in advance. I understand if I miss an appointment without canceling 24 hours in advance I will be charged a $25 no-show fee and I will not be allowed to schedule another appointment until that fee is paid in full. **Initial**_________

Returned Checks
A $25.00 fee will be added to your account for all returned and NSF checks. This must be paid in full within (10) days. **Initial**_________

Forms
There is a $20 fee for Letters of Medical Necessity or filing claims appeals if Doctor Intervention is required. There is a $10 fee for copies of a Patient Account Year End Summary and any statements in excess of initial statement. There will be a $20 fee for same day forms otherwise the turn around time for all forms is **5 to 7 business days**. There is a Records copying fee which is calculated in accordance with the State if IL Laws.

I fully understand that I am ultimately responsible for any and all charges associated with my account and that if I fail to pay any amount due, I will also be responsible for all collection fees, court costs, attorney fees and any other charges incurred in the collection of any balance in accordance with this facility’s contract with the collection agency.

Initial________

I have read the above policy regarding my financial responsibility to Willow Oak Pediatrics, for providing medical services to me or the patient listed below. I authorize my insurer to pay any benefits directly to Willow Oak Pediatrics. I understand any amount remaining after such payment has been made by my insurance carrier becomes the patient’s responsibility.

Patient Name:____ **Date of Birth**: _____/______/______

______________________________________ ___________________

Signature if Guardian or Parent **Date**