Provida Health Center, SC
18931 West Washington Street, Suite 100
Grayslake, Illinois 60030-2073

PRACTICE GUIDELINES AND PATIENT FINANCIAL POLICIES

Thank you for selecting our practice for your family's primary health care needs. Please review each of the guidelines outlined below. As a condition of acceptance as a patient and treatment we require that you or your financial guarantor initial each item and sign the bottom of this document. Terms cannot be altered in any way.

Initials	Item#	Policy — Effective July 15, 2017
	1.	**Emergencies:** Our providers will make every effort to receive your calls and respond promptly. In an emergency you will call 911, receive paramedic intervention, or seek the nearest emergency room.
	2.	**Prescription Refills:** It is our policy that you should be responsible to know when your medications must be refilled at least a week before you are out. Medications are refilled at the patient visit. This includes all mail-order prescriptions. We cannot take week-end, walk-in, after hours, or phone call refill requests.
	3.	**Telephone Encounters and Sick Patients:** Our practitioners do not treat new patients or new illnesses over the telephone. The physician may elect to treat an existing patient seeking continuing care for an existing straight forward illness over the telephone. Such consultations are provided at fee of $35. Most insurance companies do not cover the costs for these encounters. Payment for these services is your responsibility.
	4.	**Information:** You agree to provide your correct name, current and correct address, cellular or other phone number, email address, insurance information, social security number, driver's license or picture identification at the time of registration as requested by the practice at any time.
	5.	**Financial Responsibility:** By these initials and your signature below, you accept financial responsibility for all charges for services rendered to you. If a minor or under guardianship, the parent or guardian accompanying the patient assumes this liability. Minors are not allowed without a parent or guardian.
	6.	**Payment Methods:** We accept cash, check, and several major credit cards. We require a credit card on file for all patients for payment of any balance after insurance pays their portion. Reception staff may be contacted regarding credit cards accepted or insurance companies in which the practice participates.
	7.	**Appointments:** Our office will schedule appointments as a common courtesy for patients and in consideration of your time. As such, we require a minimum of 24 hours [or the Friday before a Monday appointment] notice of cancellation as a courtesy to other patients seeking services. A fee of $50 will be charged for non-cancelled and missed appointments. A fee of $100 will be charged for the second consecutive missed appointment. A third consecutive missed appointment will result in discharge from the practice.
	8.	**Forms Fees:** Our practice charges for additional paperwork outside of the completion of the medical record. The following are examples of forms that will incur a fee payable by you: (a) duplicate prescriptions, orders, or referrals; (b) single page forms; (c) multi-page forms; (d) FMLA, immigration, disability, and driver's license forms. We will notify you of the cost of completing your form upon review and collect the fee prior to completion of the form.
	9.	**Medical Records:** The medical chart is the property of the practice. However, copies of your pertinent medical information are available upon request. Provida Family Medicine contracts with MediCopy Services to copy and provide all medical records request from our office. Fees for copies of Medical Records are according to those published annually by the State of Illinois Comptroller's Office. This fee schedule is available upon request.

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10. **Insurance Co-Payments, Deductibles, and Co-insurance:** Insurance companies do not pay all fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. All co-payments, deductibles, co-insurance, non-covered services are to be paid in a timely fashion according to office policies. If requested, and as a condition of service, you agree to sign a "advanced beneficiary notice" if we determine or question your insurance coverage. You accept responsibility for all such expenses even if your insurance company is billed as a courtesy.

11. **Usual and Customary:** Some insurance plans may indicate that our fees are above "usual and customary." As a result, your plan may reduce our fee to an "allowed amount" before calculating payment. This practice does not recognize a specific carrier's use of these terms. As such, unless we have specifically contracted with the carrier, it is expected that you will be liable for our full fees

12. **Slow Insurance Response:** You agree that if your insurance company takes more than 90 days to respond to your insurance claim that we shall consider your services your financial responsibility and **the full amount will be charged to your credit or debit card on file.** It will be your responsibility to seek reimbursement from your insurance company.

13. **Accident & Workers Compensation:** Although our office is happy to treat your medical conditions, if the cause is related to an auto or work-related accident you will be required to pay the full fees at the time of your visit.

14. **Statement Policy:** Our office does not send monthly statements. You will receive a letter in the mail from your insurance plan that explains how much of your office visit they pay and how much you pay. This is called an Explanation of Benefits (EOB). This letter tells you exactly, according to your health insurance coverage, how much of your health care bill is your responsibility and how much is the responsibility of your insurance to pay. Any balance after insurance pays will be charged to your credit or debit card. **You understand that if we participate with your insurance company, the charging of your debit or credit card may be delayed until your insurance responds to a claim for payment of services.** Such a delay can take months. You understand that such a delay does not alter our policy of patient financial responsibility and you will be liable for all service fees.

15. **Collection and Bank Fees:** You agree to keep a valid credit or debit card on file. If your credit or debit card information changes, you agree to contact us with the updated information. If your credit or debit card is declined, we will contact you for new information. If you do not respond with new credit or debit card information, your account is subject to transfer to an outside collection agency. These agencies charge fees. You agree to be liable for all such collection expense, legal fees and court costs. In addition, banks charge for checks that do not clear or cannot be cashed. You agree to be liable for all such fees with a minimum charge of $35.

16. **Patient Discharge:** The practice reserves the right to discharge a patient for any reason. Please note that discharges may occur for failure to meet your obligations under this document. In addition, because of care quality considerations, the practice may discharge you for failure to comply with treatment plan(s) as outlined by your practitioner.

17. **Insurance Claims:** If applicable, our office will submit insurance claims. You agree to allow our practice to "accept assignment" of benefits and receive payment directly from your insurance company. In the event your insurer sends payment for a claim from our office to you directly, you agree to endorse the payment to our practice in fulfillment of any amounts due within 10 days of postmark.

I have read and understand all the terms of this policy and by my initials and my signature below, I attest that I fully understand each item and agree to the terms above.

_____ _____

Signature Date

_____

Printed Name