FINANCIAL POLICY

To help us provide the most efficient and reasonable health care services, it is necessary for us to have a financial policy stating our requirements for payment of services provided to patients.

The Vein and Laser Center of Elgin Cardiac Surgery, S.C. is committed to providing you with the best possible care. Charges for services rendered have been determined based on usual and customary fees for this area. If you have questions in regard to your bill, please contact our billing office at (847) 695-1620. **The doctor does not take calls in regards to your bill.**

Patients are responsible for the payment of all services provided by the Vein and Laser Center of Elgin Cardiac Surgery, S.C. However, it is our policy to file your insurance *as a courtesy* if we have accurate and complete insurance information. Our relationship with your insurance company is important to us. Therefore, we cannot legally write-off your co-pay, coinsurance, or deductible. If you need to make special payment arrangements, contact our billing office. If, however, your account is ever delinquent and placed with our collection service, an additional 33 1/3% of your outstanding balance will be added to the account.

Your health insurance is a contract between you and your insurance company. It is your responsibility to obtain a referral from your primary care physician if necessary. You are responsible for any balance not paid by the insurance company within 60 days. Please be aware that some services may not be covered by your insurance policy.

Assignment of Insurance Benefits: I hereby authorize direct payment of benefits to the Vein and Laser Center of Elgin Cardiac Surgery S.C. for services rendered.

Authorization for Release of Information: I hereby authorize the Vein and Laser Center of Elgin Cardiac Surgery, S.C. to release any medical information necessary for the processing of my insurance claim if requested by my insurance company.

I hereby understand the financial policy of this office. I guarantee payment of all charges incurred for the account of the below patient. I further agree to pay any attorney's fees, court costs, and related collection fees incurred should it become necessary to refer my account to a collection agency.

____________________________________ ______________________
Patient or Responsible Party Signature Date

PATIENT NAME: ____