FINANCIAL POLICY

Patient Name: _____ DOB: _____ Date: _____

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policies our staff is trained to consistently inform you of the financial payment policies of this office. The policies for Medical and Cosmetic services vary, so please take the time to read this policy.

MEDICAL VISITS

INSURANCE

Our office participates with many managed care insurance companies. Should your insurance coverage be with one of these companies, we will bill your insurance. However, co-payments and non-covered services are the responsibility of the patient, and payment is expected at the time services are rendered. Co-insurance and deductibles will be billed once we receive notification from your insurance carrier. If you have insurance with a company or plan we do not participate in, payment is due at the time of service. In this case, it is your responsibility to contact your insurance company to seek any reimbursement due to you. All HMO members must have an active authorized referral for every visit. The referral will be issued by the patient's PCP.

If you have a deductible plan (Annual deductible for an individual of $100.00 or above), we will require a credit card, debit card, or (HSA + CC) to be on file with our office. A credit card on file will be used to pay account balances after insurance adjudication has been deemed the patient's responsibility.

If you are uncertain whether your insurance plan covers our medical provider and medical services, please call your insurance company before your visit.

- **Co-pays are due in full at the time of service.**
- **Forms of Payment:** Cash, Check, Visa, MasterCard, Discover and American Express
- **Credit Card Payments:** There is a 3% surcharge when using a credit card to cover the cost of credit card acceptance. There is no fee for debit cards.
- **Returned Check Fee:** $50.00
- **Cancellation Fee:** In the event an appointment is missed or not rescheduled/canceled within 24 hours of your appointment time, you will be charged a $50.00 cancellation fee.
- **Late Arrival:** If you are running late for your appointment, please call our office. As a courtesy to others and in order to ensure proper treatment time, we allow 15 minutes for running late. Any time after will be considered a cancellation, and you will need to reschedule. A cancellation fee will also be assessed.
- **Past Due Balances:** In the event your account becomes 90 days past due, your account will be turned over to collections.

FINANCIAL POLICY

COSMETIC VISITS

Cosmetic visits, treatments, procedures, and physician-grade skincare products provided in this office are not considered medically necessary and are not covered by insurance.

- **Payment is due in full at the time of the visit.**
- **Forms of Payment:** Cash, Visa, MasterCard, Discover and American Express. Care Credit. Personal checks are **not** accepted.
- **Credit Card Payments:** There is a 3% surcharge when using a credit card to cover the cost of credit card acceptance. There is no fee for debit cards.
- **Cancellation Fee:** In the event an appointment is missed or not rescheduled/canceled within 24 hours of your appointment time, you will be charged a $50.00 cancellation fee.
- **Late Arrival:** If you are running late for your appointment, please call our office. As a courtesy to others and in order to ensure proper treatment time, we allow 15 minutes for running late. Any time after will be considered a cancellation, and you will need to reschedule. A cancellation fee will also be assessed.

HSA/FSA Accounts

If a patient receives a cosmetic treatment to treat a medical condition as determined by a Medical Provider, we will accept payment from an HSA account. You will be provided a detailed receipt that you may submit for reimbursement to your HSA account. We can only provide the description of the service rendered. We will not be able to provide any CPT codes for cosmetic treatments.

Patient Acknowledgment

By signing below I acknowledge that I have read, understand, and agree with the terms and conditions of the financial policy of this office. I guarantee payment of all charges incurred for the account of the patient listed above. I may request a copy of this policy at any time.

_____ _____

Signature of Responsible Party Relationship to Patient Date

_____ _____

Print Name of Responsible Party, if different from Patient Date

911 North Plum Grove Rd. Suite A
Schaumburg, IL 60173
O: (847) 534-0700

Est: 06/2021 VZ, Rev: 07/09/2024 VZ, 08/05/2024 VZ