PATIENT FINANCIAL RESPONSIBILITY AGREEMENT
AUTHORIZATION TO RELEASE MEDICAL INFORMATION
TWO SIGNATURES REQUIRED

Our commitment to you

We will charge for only services rendered, supplies used, and equipment provided you. We will honor the terms of insurance contracts that we have signed. We will submit claims to your insurance company in a timely manner. We will strive to address your questions regarding financial matters related to your care. We will make reasonable efforts to refund amounts due you within ten days of determination by us that a refund is due you. We will put forth our best effort to provide you with a copy of all charges and payments to date upon your request without charge to you.

You accept the following terms by signing this Agreement

[Signature required prior to receiving treatment.]

You will provide us valid readable photo identification such as a driver's license or other official ID, and authorize us to make a copy for your medical file.

You agree to pay for those services rendered and not paid by your insurance company. We hold the option to request from you prior to rendering of services payment a deposit to be applied toward insurance deductibles, coinsurance/copay obligations and out of pocket amounts. Deposits may be required. [The latter applies to patients with traditional Medicare insurance only when you have signed an advance beneficiary notice.]. We cannot guarantee the terms of your insurance coverage. It is your responsibility to know your plan's benefits, requirements and exclusions for treatment. Your coverage is a contract between you and you insurance company.

We may require that you provide us a copy of a valid credit card to keep on file and by doing so authorize us to charge any outstanding balance following processing by your insurer for amounts due us. By doing so you further agree to the provisions below.

You agree that we hold the option to charge the following fees and take the following actions on past due amounts for services rendered to you: 1) Bill you any balance due if your insurance company fails to process and make payment of a clean insurance claim within 45 days of the date sent. This shall apply to primary and secondary insurance claims including those for the State of Illinois, 2) Charge you a nonrefundable late fee of $25 should your patient balance become past due over 30 days from the date of the first patient invoice, 3) Charge you interest for past due amounts at an annual rate of 12% or the highest rate allowed under IL law if lower, 4) To direct an independent collections agency with whom we contract to take all such actions as allowed under law to collect amounts due us for balances over 45 days past due from the date of the first patient invoice, 5) charge you an additional one-time nonrefundable fee equal to the fee charged to us by the collections agency as allowed under IL law, such fee equal to 30% or 35% of the past due balance depending on charges to us issued by the collections company.

CONTINUED ON OTHER SIDE

We may at our option refuse insurance coverage and/or refuse limits imposed on our fees from any insurance company with whom we do not contract. Such services shall be treated as cash, payment due at time of service.

We may charge a $25 no show fee for repeated cancellations of appointments without 24 hours advance notice to us by you. We will not charge for cancellations due to personal emergencies or inclement weather. Please do not venture out when the weather puts you at risk. You will not be charged a no-show fee.

I certify that if I chose to have charges for services billed to my insurance company, I have provided a true and correct copy of my current insurance identification card(s) and will provide information reasonably requested by this office or its billing company to process an insurance claim(s).

I understand that any modifications I make to this Agreement shall be deemed invalid by mutual agreement. I understand that my acceptance treatment from Dr. Florence Ouska-Griffin today and on any date in the future is sufficient evidence of my agreement to all the above terms without modification and shall become immediately binding even without my signature below.

I certify that I have read and agree to the above terms and conditions without modification.

Agreed to on this date
Patient _____ **Date:** _____
OR
Responsible party signature: _____ **Date:** _____

Authorization to release medical information

I hereby authorize the doctor and authorized staff to release of all information to secure the payment of benefits provided from this date forward. I authorize the use of this signature or a copy thereof for all services rendered to me on all insurance claims, my primary care physician, and/or other treating physician.

Agreed to on this date
Patient _____ **Date:** _____
OR
Responsible party signature: _____ **Date:** _____

In office original: 01/01/2009, last amended: 11/10/2014