EXHALE SINUS
TMJ | HEADACHE | SLEEP

814 E Woodfield Rd.
Schaumburg, IL 60173
Tel: 773-234-5880
Fax: 708-273-5332

OFFICE FINANCIAL POLICY

INSURANCE There are numerous insurance networks across different regions and states. Our providers are not part of all these networks and therefore, they have not agreed to accept a reduced fee from all insurance companies.

Insurance coverage is a contract between the patient and the insurance carrier, it is the responsibility of the patient/ guardian to know and understand the benefits of his/her particular insurance plan, and whether or not physician is in network. We will file claims with insurance and by law, the insurance carrier must remit payment or deny the insurance claim within 30 days of initial notice. Not all insurance plans cover all services and in the event your insurance plan determines a services to be "not covered", the patient will be responsible for the complete charge. If insurance problems occur, we will bill the patient and the patient may be asked to assist the office in contacting the carrier and/or in filing a complaint with the State Insurance Commissioner.

PAYMENT:

1. If our physician is ***contracted with your insurance plan, we are required to collect the co-payment at the time of service.*** If our physician is not contracted with your insurance plan, ***you are required to remit full payment at the time of visit.***
2. We have the capability to perform cost of care at the time of service to determine the patient responsibility based on the insurance plan. It is our policy to collect any deductible, co-insurance and/ or non-covered charges at this time.
3. ***Fees for any procedures are not included with the office exam and may be applied to your deductible or co-insurance.***
4. **SELF PAY patients only: All procedures are subject to an additional charge. _____(Initial)**
5. **When you or a family member provide us with a credit card number, you are giving us permission to use the card to pay the account balance. All credit card transactions are assessed a 3% transaction fee.**
6. Any questions concerning office financial policy or patient's need of assistance should be directed to the billing specialists or practice manager immediately.
7. All patients will be required to establish financial arrangements for payment of their account.
8. Accounts that have an outstanding balance for over 60 days may be forwarded to an outside collection agency and, 18% service fee will be added to the account. The patient is responsible for the entire balance including the 18% fee.
9. Our physician accepts Medicare assignment. Medicare part B has **a calendar year deductible and a 20% co-insurance**. All secondary insurances may or may not cover your Medicare annual deductible. Patient is responsible for this balance.
10. The office may use an AI-based medical scribe during your appointment to assist with documentation. This technology is HIPAA-compliant and helps improve visit accuracy and efficiency. By signing this form, you consent to the use of an AI scribe during your appointment. _____ (Initial)
11. All patients will receive electronic statements by default. By signing this form, you acknowledge and agree to receive statements electronically. _____ (Initial)
12. We use a HIPAA-compliant texting platform to communicate with patients. By signing below, you consent to receive secure appointment reminders, instructions, and communications through this method.

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CANCELLATION/OR MISSED APPOINTMENTS: If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a missed appointment fee. Office visit: $65 Allergy Testing: $100 Botox Testing: $100 and Procedure/Surgery: $500 **must cancel 2 weeks before** your scheduled date**.** _____ **(Initial)**

Cost of Care (COC) Estimate: Will be collected at your pre-op appointment or within one week before your procedure. _____ **(Initial)**

Procedure CPT Code Denials: If for any reason your insurance denies any procedure codes even after receiving an authorization, it is the patient responsibility for any balance/charge. _____ **(Initial)**

SELF PAY: At the time an appointment is scheduled, the patient will need to pay a $100 appointment deposit to secure the scheduled appointment. This is a non-refundable amount if the appointment is canceled in less than 24 hours of the scheduled appointment and/or you miss the appointment. A full payment is required at the time of the visit, for all services provided on the day of appointment. _____ **(Initial)**

I have read this policy and hereby authorize my insurance benefits to be paid directly to the physician's office. I understand that I am responsible for any non-covered services. I also authorize the release of medical information necessary to process claims with my insurance.

Patient or Guardian Signature: _____ **Date:** _____