Logan Primary Care

405 Rushing Drive
Herrin, IL 62948

502 W. St. Louis Street
West Frankfort, IL 62896

FINANCIAL POLICY

Thank you for choosing Logan Primary Care as your health care provider. We are committed to providing you with the best care we can offer. Please understand that payment of your bill is your part of the contract and a part of your treatment plan. You can help us by paying your bill on time, and help us keep more efficient and reduce the cost of medical care.

All patients must complete our information and insurance questionnaire before seeing a medical provider. Please have your insurance card available.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE
WE ACCEPT CASH, CHECKS, CREDIT CARDS, MONEY ORDERS, AND TRAVELERS CHECKS

REGARDING INSURANCE

Participating Provider: Co-pays, coinsurance and deductibles are due **prior to your visit**, unless otherwise specified in our agreement with your insurance company. Please be aware that some, and perhaps all, of the services provided may be "non-covered" services and therefore, you will be responsible for the balance of your bill.

If your insurance company has not paid your account in full in 45 days, pursuant to our agreement with your insurance company, the balance will automatically become your responsibility. It is **your responsibility** to see that your account is paid. It is **your responsibility** to see that the information we have to bill your insurance carrier is current and correct.

Non-participating Provider: Payment is expected at the time of service. We will bill your primary insurance company one time as a courtesy to you, if your insurance company denies payment, you are responsible for any appeal process. If you want to submit your initial bill, we will provide you with the necessary information to bill your insurance carrier, so that you can be reimbursed. Your insurance policy is a contract between you and your insurance company. We **are not** a party to that contract.

Payments: Logan Primary Care accepts cash, check, credit cards, Travelers checks, and money orders. We also offer outside financing with an approved credit check.

Statements: Statements will be sent to you once a month. Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued and is past due if not paid in 15 days.

Patient Overpayments: Overpayments will only be returned to you if you have no outstanding balances due on you or your dependents accounts.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all the collection costs, which are incurred. If we have to refer collection of the balance to an attorney, you agree to pay all attorney fees, which we incur, plus all court costs. In case of suit, you agree to venue shall be in Williamson County, IL. Your account will also be reported to a credit reporting agency which may affect your credit rating.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Med Station Fee: A $20 Med Station fee will be charged for any services incurred in the Med Station during regularly scheduled evening, weekend or holiday office hours, in addition to the basic service charges. This fee is not covered by Medicare or several other insurance carriers. Payment will need to be made **prior to your visit**.

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Resp. Party Initials

Re-Billing Fee: A pre-paid re-billing fee of $5 will be required for any service that the responsible party requests to be re-billed. This request **must be** in writing and the $5.00 fee **must be** paid before re-billing.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Returned Checks: There is a fee of $25 for any checks returned by the bank. If you do not respond from our collection correspondence within 2 weeks, your check plus the return check fee will be turned over to the States Attorneys office or our attorney for collection. You will be responsible for all legal fees in attempts to collect debt.

Motor Vehicle Accident: Payment is expected at the time of service. It is **your** responsibility to collect reimbursement from your auto insurance.

Worker's Compensation Claims: Our practice must have written or verbal authorization from your supervisor or employer **before** billing them for your treatment. If consent is not obtained, payment **is due** at the time of service.

Missed Appointments: We reserve the right to bill for a missed appointment if not cancelled. If a patient demonstrates a pattern of missed appointments without notification of cancellation, that patient will no longer be eligible to receive services at Logan Primary Care. Written notification will be sent to that patient.

Delinquent Accounts: We will turn delinquent accounts over 90 days past due to a collection agency. The patient will be responsible for court costs and attorney fees incurred in the collection of said account.

Insurance Numbers and Policies: It is the responsibility of the patient or their responsible party to provide Logan Primary Care with current insurance information and pertinent billing information at the time of service. If your current insurance card is requested at the time of service, you will be expected to provide it. Logan Primary Care reserves the right to cancel appointments if you are unable to provide current information.

I have read the information provided above and understand my responsibilities in relation to service at Logan Primary Care. I agree to this policy. I understand that I have the right to ask the cost of any service before it is rendered and may refuse to accept that service. I understand that if the service is provided, I will be responsible for payment of that service.

I authorize release of medical information necessary to process insurance claims for any company. I also authorize benefits entitled as stated previously in this agreement, to be paid directly to Logan Primary Care for services I, or anyone for whom I am responsible, have received.

I understand that failure to pay for services will be considered cause for Logan Primary Care to refuse further service to me, or anyone for whom I am responsible.

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Print Patient's Name **Social Security Number**

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Print Responsible Party (If not the patient) **Social Security Number**

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Signature of Responsible Party **Date**