

**Ear Institute of Chicago, LLC
FINANCIAL POLICY**

Business office location: 11 Salt Creek Lane, Suite 101, Hinsdale, IL 60521
Phone: (630) 789-3110

Thank you for choosing Drs. Wiet, Battista, & Kumar as your provider. The following is a statement of our Financial Policy that we require you read, initial each section and sign the bottom prior to your first visit.

PPO Plans

Most members covered under this type of plan are required to make some type of payment for services that are rendered. This may be in the form of co-payment, deductible, or co-insurance. If your plan has a co-payment, you will be expected to pay your co-payment prior to being seen by the doctor. Co-payments, deductibles, and co-insurance are requirements of your insurance plan and we are required under our contract with these plans to collect these amounts from you. _____ Initials

POS and HMO Plans

Most of the members covered under POS and HMO plans also owe co-payments, and members of POS plans may also owe deductible, and/or co-insurance. Co-payments will be collected prior to being seen by the doctor. You will be billed for co-insurance and deductible amounts. We are required under our contract with these plans to collect co-pays, deductibles and co-insurance amounts from you. _____ Initials

Office Testing and Procedures

Fees for office visits do not include audio testing or office procedures. Separate charges for these services will be billed according to insurance carrier guidelines. Deductible and co-insurance amounts will be determined by your carrier and will be due from you. _____ Initials

Balances on Account

All previous balances are to be paid in full prior to additional services being rendered. _____ Initials

NSF

Checks or credit card refusals will have a \$30.00 service fee added to the account. _____ Initials

Re-Billing Charges

In the event that your insurance company has paid their portion and the balance remaining is your financial responsibility, we expect that you will pay any co-insurance, deductible, or any other balance in a timely manner. Should your payment fail to reach us within 60 days of billing, a service fee of \$10.00 will be added to your total balance due. This amount will be added to your outstanding balance each month until your account is paid in full. For your convenience, we accept Visa and MasterCard payments by phone. _____ Initials

No-Show Appointments

You must notify our office at least 24 hours prior to your scheduled appointment if you intend to cancel. Patients who fail to notify us of their intent to cancel an appointment will be charged \$50.00 _____ Initials

Collections

Should it become necessary for us to utilize the services of an outside collection agency in order to collect the amounts which are due and owed by you under the terms of your insurance coverage, you will be held liable for any and all collection agency fees and/or attorney fees which will be approximately 35% and above your actual outstanding balance. Further, information that is helpful or necessary for collection purposes will be forwarded to our professional collection agency. _____ Initials

Thank you for reviewing our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy and understand and agree to adhere to this Policy.

_____ Date _____
Signature of patient or responsible party