Midwest Allergy Inc

1425 N McLean Blvd - Ste 100
Elgin, IL 60123
(847) 931-1999

10001 W. Roosevelt Rd. - Ste 304
Westchester, IL 60154
(708) 344-3550

7808 College Drive
Palos Heights, IL 60643
(708) 361-0730

Office and Financial Policies

Welcome and thank you for choosing Ghani Asthma and Allergy Center for your medical care. We are committed to providing you with high quality care in an efficient, timely, and cost-effective manner. We hope that by providing you with our policies in advance, we can prevent any misunderstanding or frustration at the time of your visit.

Initial: ____ **Insurance:** When making an appointment with one of our physicians or physician assistants, it is your responsibility to confirm with our office and your insurance company that the physician is currently under contract with your plan. A copy of your up-to-date insurance card is needed at all times. As a service to you, we will bill most insurance companies. While providing this service, it is extremely difficult for us, and our Doctors, to be aware of the multitude of individual requirements for each of these plans. Each plan has its own stipulations regarding the coverage of, and payment for, medical services; therefore, it is your responsibility to know your plan's benefit policies prior to your appointment. If your plan requires that you have a referral prior to seeing a specialist, please contact your primary care physician so that you will have the referral in hand at the time of your appointment. In order for us to bill your insurance, we must have a current copy of your medical card, along with all required information. If this is not provided at the time of your appointment, you may reschedule, put a credit card on file or pay in full at the time of service. If you put a credit card on file, you have 24 hours to provide the necessary insurance information before your credit card will be charged. We allow 60 days for your insurance to respond to a claim, and 90 days for them to process and/or issue payment. If your insurance does not respond or pay your claim within 90 days, the full balance will become the patient/guarantor's responsibility.

***** Please remember that all copayments must be made before seeing the physician/physician assistant. If your insurance requires that you pay a deductible or percentage of the charges, that payment should be made as soon as you are aware of your responsibility. Making timely payments helps to keep our costs down, thus keeping your costs down.

Initial: ____ **HMO PATIENTS**: If your primary care physician is referring you to this practice, you must have a referral form/number for each visit. It is **your responsibility** to make sure that you have a valid referral for each visit. Without a valid referral, you must pay in full at the time of service in order to receive treatment. All HMO patients (both those primary to this practice and these being seen by referral) must pay their co-payments before being seen by the physician or physician assistant.

Initial: ____ **PPO/PRIVATE INSURANCE PATIENTS**: We will submit all charges to your insurance company. You will be billed for any portion your insurance company did not pay. Payment, or arrangements for payment, should be made within 30 days of receiving you first notice that a payment is due.

Initial: ____ **MEDICARE PATIENTS**: A copy of your up-to-date Medicare card and any secondary insurance cards is needed at each visit. We do accept Medicare assignment. We will submit charges to Medicare and your secondary insurance company. You will be billed for any portion of your deductible and/or 20% copayment that your insurance company did not pay. Payment, or arrangements for payment, should be made within 30 days of receiving you first notice that a payment is due.

It is your responsibility to make sure that this office has accurate insurance information for you. Any time you have a change in coverage, it is your responsibility to notify us as soon as possible. If you fail to do this, you will be personally responsible for payment of any charges that were incurred from the time of the change to the time this office was notified.

Initial: _____

Midwest Allergy Inc

1425 N McLean Blvd - Ste 100
Elgin, IL 60123
(847) 931-1999

10001 W. Roosevelt Rd. - Ste 304
Westchester, IL 60154
(708) 344-3550

7808 College Drive
Palos Heights, IL 60643
(708) 361-0730

Office and Financial Policies

Initial: _____ **Check-in:** We do our best to keep on schedule, so please arrive for your appointment on time so that other patients are not inconvenienced. Bring your current insurance card to EACH VISIT. Without the insurance card, we will be unable to file your insurance and you will be responsible for the charges for the day. On follow-up visits, you will be asked to verify demographic and insurance information so that our records remain up to date.

Initial: _____ **Check-out:** Please be prepared to pay any past balances on your account. Payment of co-pays and non-covered services will be required at the time of service. For your convenience, we take cash, check, MasterCard, Visa, Discover, and American Express.

Initial: _____ **Non-covered services:** If you are coming in for a non-covered service, please be prepared to pay for the service in full. Cosmetic procedures including, but not limited to Varicose Veins, Botox, Laser Hair Removal, Laser Tattoo Removal, Photo-rejuvenation, Chemical Peels, and Micro-Dermabrasions are not covered by insurance and claims will not be filed for them.

Initial: _____ **No Shows and Late Cancellations:** We require a 24-hour advance notice if you must cancel your appointment. If you cancel on the same day, you will be considered a NO SHOW for that visit. Each patient is allowed ONE NO SHOW without penalty. The second NO SHOW with result in a $25 charge to your account. All subsequent NO SHOW appointments thereafter will also result in a $25 charge to your account.

Initial: _____ **Minors:** A parent or guardian MUST accompany a minor for all visits to our office. The parent(s) or guardian(s) are responsible for providing current insurance information for the minor and/or payment in full for services provided.

I have read, understand and agree to the above office and financial policies. Any questions I had were answered and I understand my responsibilities and do agree to comply with them. I do hereby authorize this medical practice to release to my insurance company(ies) any information, including but not limited to diagnosis and record of treatment or examination which were rendered to me. I also authorize payment of benefits directly to this practice for any services rendered. I do understand that I am financially responsible for all charges and that this does not release me from the responsibility of making sure that payment is made in a timely manner. I also understand that it is my responsibility to settle any dispute regarding what benefits are due from the insurance company. I also understand that if I allow this account to become delinquent that it may be turned over to an outside agency for collection. If this should occur, I may be responsible for any collections fees in addition to the original amount due. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release on information necessary for insurance filing and pre-certification by signing this statement.

Patient name: (print) _____ Date of birth: _____/_____/_____

Signature of patient: _____ Date: _____/_____/_____

If applicable:
Name of parent/guardian/responsible party: (print) _____

Signature: _____ Relationship to patient: _____

Date: _____/_____/_____