PrairieShore™ PAIN CENTER

185 Milwaukee Ave, Ste 230
Lincolnshire, IL 60069

847-883-0077 Phone
847-883-0078 Fax

PrairieShorePainCenter.com

Financial Agreement

Thank you for trusting PrairieShore™ Pain Center to partner in your health care. This financial agreement should answer questions regarding patient and insurance responsibility for services rendered. Please read this agreement, ask us any questions you may have, and sign in the space provided. You will be given a copy of this agreement for your records, if requested.

INSURANCE
Your insurance coverage is a contract between you and the insurance company, and it is your responsibility to know your insurance benefits. As a courtesy, we will bill both your primary and secondary insurance companies. We will submit your claims and assist you in any way we reasonably can to help get your claims processed. In order to do this, we must receive all the information necessary to bill. If the information is not supplied, you will be billed, and payment in full will be your responsibility and will be expected within 30 days of receipt of statement.

MEDICARE
We participate in the Medicare program. You are responsible for your co-insurance, any deductibles that have not yet been met, and services that are identified as patient responsibility on your Medicare Explanation of Benefits. We strive to inform our Medicare patients of services that will not be covered. We may ask you to sign an Advanced Beneficiary Notice, which notifies you of your financial responsibility for certain medical services.

MANAGED CARE
Many patients are enrolled in Managed Care Products. In order for us to obtain referrals and/or pre-authorizations for procedures, it is important that we have your current insurance information. Depending on individual policies, your procedure may not be a covered benefit. It is your responsibility to check for optimal coverage and policy limitations, and to obtain referrals as required by your insurance company. Please contact your insurance company with questions regarding your coverage.

PATIENT RESPONSIBILITY FOR PAYMENT
You are responsible for payment of any co-payment, co-insurance, deductible or service not covered by your insurance and handling, collection or attorney fees. If you do not have insurance, you are responsible for payment of all services. Co-payments are due at the time of your service. Patient due balances noted on your monthly statement are due within 30 days of receipt. We will bill appropriate insurance if all required information is provided.

It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time limit within which PrairieShore Pain Center must submit a claim on your behalf to your insurer. If PrairieShore Pain Center is unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for the charges.

DEPOSITS
New patients without insurance, or if insurance co-payment and coverage cannot be verified, are required to a deposit (full payment for self-pay patients) on or before the first date service. If insurance payment results in a credit balance, it will be refunded to you within 30 days of your request.

PAYMENT OPTIONS
We understand that financial circumstances vary from patient to patient. If you are unable to pay your patient due balance in full, you must call our business office at (847) 883-0077 to make payment arrangements.

I have received this financial policy, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts could hinder ongoing medical care. I also acknowledge that I have received a copy of this financial agreement for my records, if requested.

Patient Signature	Printed Name	Date
Parent/Guardian Signature	Printed Name	Date