

CHICAGO LAKESHORE MEDICAL ASSOCIATES, LTD

Notice of Patient Responsibility

2010

PATIENT NAME: _____ **ACCOUNT NUMBER:** _____

✓ **FINANCIAL RESPONSIBILITY:** As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. Not all services are covered in all insurance contracts. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges. To find out what your insurance plan covers and what your financial obligation may be, call the customer service or member services department of your insurance company (the phone numbers are on your insurance card).

✓ **INSURANCE INFORMATION:** You are responsible to notify us of your insurance and to provide the necessary information about your insurance plan; therefore, please have your current insurance card with you at all times, as well as a photo ID. It is your responsibility to know your insurance company's patient responsibilities and procedures. If proper procedures are not followed, you may be liable for full payment of the bill. If your insurance company requires a referral and/or prior authorization contact your primary care physician prior to seeing a specialist.

✓ **NO SHOW/CANCELLATION:** We request 24 hour notification of any need to cancel a visit. Your courtesy will allow your physician to accommodate a patient who may need acute medical care. Failure to cancel may result in a \$50.00 fee.

✓ **TELEPHONE/ONLINE CONSULTATION:** Medical advice or treatment given over the phone or by email may incur a charge at the discretion of the physician.

✓ **BALANCE DUE (co-insurance/co-payment/deductible):** Resolution of outstanding balances is expected prior to obtaining additional services from CLSMA.

BILLING

INSURANCE DISCLAIMER: I understand that I have not provided complete insurance information to CLSMA for my office visit today. Without this information CLSMA may be unable to provide services according to their contract with my insurance company (for example, laboratory services may be sent to the wrong lab vendor). If this occurs, I understand I will be responsible for payment of any charges incurred by my failure to provide complete insurance information.

Initial _____ Date _____

FOR MEDICARE PATIENTS: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Initial _____ Date _____

FOR ALL OTHER PATIENTS: I hereby authorize payment directly to Chicago Lake Shore Medical Associates, Ltd for benefits otherwise payable to me. I understand that I am financially responsible for the charges not covered by this authorization. I authorize Chicago Lake Shore Medical to release any information acquired in the course of my examination or treatment.

Initial _____ Date _____

FOR PATIENTS UNABLE TO PAY AT THE TIME OF SERVICE: I have been informed that per my insurance carrier it is my responsibility to pay my portion at the time of service. Or I am a true self-pay and balance due is my responsibility. At this time I cannot make my payment but I will mail a check or call to make a credit card payment within 3 days. In the future I will be prepared to make a payment at time of service.

Initial _____ Date _____

HIPPA

NOTICE OF PRIVACY PRACTICES: By signing below I acknowledge that I have received a copy of, read and understood CLSMA Notice of Privacy Practices.

Initial _____ Date _____

CHICAGO LAKESHORE MEDICAL ASSOCIATES, LTD

Notice of Patient Responsibility

SPECIAL INSTRUCTION

COMPLETE PHYSICAL EXAM: Your appointment today was scheduled as a complete physical. Please note that due to insurance requirements, it is a CLSMA policy that CLSMA will not re-submit and/or appeal a previously filed claim. It is your responsibility to notify us at the time of your visit of your primary reason for the scheduled appointment. Unless otherwise specified your visit will be coded as a well/routine/preventive care visit. If you are unsure of your benefits, please contact your insurance carrier today, and verify to ensure you receive the highest level of benefit coverage available.

ILLNESS/DIAGNOSIS or **WELLNESS/PREVENTION/ANNUAL EXAM** Initial _____ Date _____

SPECIALIST/CONSULTATION VISIT: INSURANCE REFERRAL: I acknowledge for today's visit that I will assume full financial responsibility for services rendered to me if my insurance carrier denies or does not cover my claim for these services because a valid referral authorization was not presented at time of service. I acknowledge it is my responsibility to understand my insurance requirements and to obtain and provide a referral and/or authorization from my insurance carrier prior to receiving services. I understand my insurance carrier will not make payment to CLSMA physician(s) unless the guidelines of the plan are followed and a valid referral authorization is obtained prior to services being rendered.

- I **DO NOT** have a referral for today's visit but choose to keep the scheduled appointment.
- Refusal of service: I have decided to cancel my appointment today because I did not obtain the appropriate authorization from my insurance carrier.

Initial _____ Date _____

WORKERS' COMPENSATION/MOTOR VEHICLE ACCIDENT: In order for our office to file a claim with your workers' compensation or motor vehicle accident insurance, we must have complete billing information at time of service. If this information is not available at the time of the visit, payment in full is expected and the payment will be refunded if a third-party makes payment and/or once complete claim information is provided by the patient.

Claim # _____ Insurance Carrier _____

Mailing Address: _____ City: _____ State: _____ Zip code: _____

Claim Adjudicator: _____ Contact Phone Number: _____

Initial _____ Date _____

FOR PATIENTS GETTING SHINGLES VACCINE (ZOSTAVAX): Zostavax is a herpes zoster vaccine and Medicare Part B will not reimburse Chicago Lake Shore Medical physicians. I understand it is my financial responsibility to pay for this vaccine at time of service. In the event another insurance carrier (secondary/supplemental or tertiary) pays CLSMA for this vaccine CLSMA will issue a refund to the patient.

Initial _____ Date _____

Signature of patient/guarantor

Date