EXPLANATION OF PRACTICE POLICY

As a courtesy to our patients, our practice will bill your insurance carrier for services furnished. However, patients should be advised that any non-covered services or unpaid balances are the responsibility of the patient. This includes personal injury, auto accidents, worker's compensation claims, etc.

If your visit is for a condition which is the result of a personal injury, we may file the charges with the medical payment portion of the personal injury insurance. When that benefit has been exhausted we will bill your health insurance. We will then lien the responsible insurance company and will expect full payment from any settlement received. However, the patient is responsible for any unpaid balances.

We will prepare any necessary forms to assist in making collections from your insurance company and will credit such collections to your account. However, we cannot render services on the assumption that your charges will be paid by your insurance company. Most misunderstandings about insurance can be avoided if you understand what your policy provides. When we process insurance claims for our patients, the insurance payments will be assigned to the practice. Your cooperation in complying with the terms of this assignment will be appreciated.

Any balance remaining unpaid by insurance will be the patient's responsibility. If it becomes necessary for the account to be sent to collection, the full collection fees, including court fees and attorney's fees, will be added to the balance due from the patient.

Credit balances on accounts less than $50 will be held on the account to defray against future services or the expenses of processing a refund unless specifically requested by the patient.

For your information, the health care professionals in this practice are financially integrated. If you are referred to McHenry County Physical Therapy for physical therapy, occupational therapy or athletic trainer services, please note that you may request and receive a referral for these services outside or independent of this practice.

RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS

I, the undersigned, hereby authorize John A. Elstrom, M.D., Robert F. Hall, Jr., M.D., Albi Qeli, M.D. or McHenry County Physical Therapy to release information to my insurance company to obtain benefits due me.

I also authorize payment of medical and surgical benefits directly to John A. Elstrom, M.D., Robert F. Hall, Jr., M.D., Albi Qeli, M.D. or McHenry County Physical Therapy.

Signed____ Date____________ For________________

STATEMENT OF FINANCIAL RESPONSIBILITY

I, the undersigned, have read and agree to all of the above and realize that all medical and surgical charges incurred by me or my dependents for services rendered by John A. Elstrom, M.D., Robert F. Hall, Jr., M.D., Albi Qeli, M.D. or McHenry County Physical Therapy are my financial responsibility. All court fees, attorney's fee, or any other fees necessary to collect this account are payable by me.

Signed____ Date_______________