Advanced Surgical Care of Northern Illinois Payment Policy

Thank you for choosing Advanced Surgical Care of Northern Illinois for your surgical needs. We are committed to providing you with quality health care and we would like you to completely understand our payment policy. A copy of our payment policy will be provided to you upon request.

1. Insurance. We participate in most insurance plans. If you are not insured by a plan, we do business with, payment in full is expected at each visit. If you are insured by a plan, we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Due to the many different insurance products available, our staff cannot guarantee your eligibility and coverage. Please be sure to check with your insurer's member benefits department about services and providers covered prior to your appointment. Many websites have erroneous information and are not a guarantee of coverage. You are responsible for requesting and obtaining a properly dated referral if required by your insurer and are responsible for payment if your claim is rejected for a lack of one.

2. Co-payments and deductibles. Payment is expected at the time of your visit. All co-payments, unmet deductibles, co-insurance, or charges not covered by your insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company. Please help us in upholding the law by paying these at each visit. We will accept cash, check, or credit card.

3. Surgical Deposit. Advanced Surgical Care will collect a surgical deposit which will be due 3 weeks prior to your procedure. This is procedure specific and will be discussed with you when scheduling your procedure.

4. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of fees charged for these services.

5. Proof of insurance. All patients must complete our patient information form before seeing a provider. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

6. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

8. Nonpayment. If your account has a balance after your insurance has paid their portion, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Patients consent to receive phone calls and/or text messages, in compliance with HIPAA, to collect past due balances and/or marketing messages. Please be aware that if a balance remains unpaid, after 30 days, we will charge your card on file for your balance in full.

9. Returned checks will incur a $30.00 service charge. You will be asked to bring cash or certified funds to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or providers. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action. All bad checks written to this office are subject to collections.

10. Billing office. If you have questions regarding any of our billing statements, our billing company can be contacted at.847-381-8161 option 5.

11. Your Medical Information:Your rights-Our responsibilities: Your privacy is important to us. Please inform the staff if you need another copy or have not received our privacy policy.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of Patient/Responsible Party: _____Date:_____