WINDY CITY ORTHOPEDICS AND SPORTS MEDICINE

2617 W. Peterson Ave. Chicago, Illinois 60659

Toll Free 877-549-4490 Chicago 773-743-1981 Suburban 847-475-0200

PAYMENT POLICY

If we are not a participating provider with your health plan, payment is due at the time of service. If Windy City Orthopedics & Sports Medicine, Ltd. is a participating provider with your health plan, we will send an itemized bill to your insurance company. However, you are financially responsible for all charges incurred whether or not your insurance covers these fees. Illinois State Insurance Law requires your insurance company to pay or deny your claim within 30 days or penalties can be applied. WCOSM does not accept THIRD PARTY LIABILITY. If your injury is a result of a motor vehicle accident or other third party, payment is expected at time of service. You are responsible for all charges not covered under your insurance contract. Payment is due upon first request. Billing fees will be applied to second and third requests for payment.

SERVICES PAYABLE AT THE TIME OF SERVICE:
Payment for supply items such as braces, crutches, and heel cushions will be due at the time of service. Your insurance contract may or may not cover supply items. Payment for forms such as disability forms, FMLA forms and work forms are due at the time of submission. You will receive a receipt and you may submit this to your insurance for reimbursement.

HMO PATIENTS:
With the exception of referrals for "fracture care" and surgery, you must have an authorization for every visit to our office. If you should receive care from our office without the necessary referral form, you will be responsible for payment of this service in full accordance with this payment policy. Surgery/Fracture care referrals are valid for 90 days only.

MEDICARE PATIENTS:
Under the Federal laws governing Medicare, you are mandated to pay your deductible and 20% copayment. You must send you Medicare EOMB to the secondary insurance upon receipt.

MISSED APPOINTMENTS:
There is a $60.00 cancellation fee if the appointment is canceled less than 24 hours.

COLLECTION: YOUR SOCIAL SECURITY NUMBER IS REQUIRED.
In the event that we do not receive payment in full from all charges billed to you in a timely manner, and we must refer your account to a collection agency, you hereby agree to pay a collection fee of 35% of the amount to be collected. This shall be in addition to the amount you owe Windy City Orthopedic & Sports Medicine, Ltd. For example, if you owe us $100 at the time we send your account to collection, you agree to pay $135 to cover your indebtedness with us. In the event that we must refer your account to an attorney for collection, you will pay attorney's fees and costs incurred necessary to collect the amount you owe to us. Since the attorney to whom we shall refer your account for collection charges a fee equal to 50% of the amount owed, you understand that in the event that you owe us $100, we shall be entitled to collect $150 plus all costs incurred in filing and prosecuting the suit to enforce our right to payment and $50 of the $150 recovered from you as referred to above will go to pay the attorney his contingent fee. In addition, all discounts given in consideration of a monthly pay plan will be reversed. The full amount of medical services provided will be due if you default on a pay plan.

I UNDERSTAND AND ACKNOWLEDGE THAT I HAVE READ THE ABOVE INFORMATION:
X Signed:_____ Date:_____

I hereby authorize all payments of surgical and/or medical benefits to be paid directly to Windy City Orthopedics & Sports Medicine, Ltd and/or G. Klaud Miller, M.D. for expenses relative to services provided.

X Signed:_____ Date:_____