PANACEA ALLERGY- LISA SULLIVAN MD SC

FINANCIAL POLICY

Dear Patient/Guardian,

We reserve the right to change our financial policy at any time.

Upon request, and with a valid insurance card on file, our office will submit claims and receive payment from your insurance company for all services rendered. Please note that:

All payments collected from patients, at the time of service or thereafter, are dictated by YOUR insurance plan at the time of service. This is based upon YOUR pre-determined agreements with YOUR employer or individual plan. "Covered benefits" is a misleading term perpetuated by the insurance industry. It does NOT mean that the insurance will pay for the service, only that they deem the service legitimate. The insurer then assigns who pays for what, calling the patient portions "deductible, co-insurance, or co-pay." We recommend that you contact your insurance company to determine the "coverage" that your plan provides. You may then ask our management how this may work with your expected visit costs.

As such, please read and initial that you understand and agree to the following:

____ I have read and understand the information provided on the "Insurance and Payment" and "Telehealth" pages on PANACEA's website, **https://www.lisasullivanmd.com**

____I understand that my insurance may not "cover" or "pay for" all the medical services provided. It is my responsibility to verify my coverage and to confirm that the provider I am seeing is "in my network", or "out of network" if I so choose.

____ I understand that it is my responsibility to provide referrals or pre-authorizations for services, BEFORE the visit, as required by my insurance plan. I will be responsible for all charges not covered due to a missing referral.

____ I understand that my insurance may have a deductible, coinsurance and/or co-payments. All co-pays, deductibles, and co-insurance amounts are due AT TIME OF SERVICE. Payment is my obligation regardless of my insurance or any other third-party (eg. guarantor/*parent/spouse/ex-spouse) involvement. If the deductible has not been met, a portion is due at each visit.

____ *I accept full responsibility for my child's medical expenses regardless of my marital status/divorce agreements.

____ I understand that any cancelled or missed appointments without adequate notice (48 business hours) may incur a **$50.00 LATE CANCEL FEE**, payable before my next appointment.

____ Cancelling said appointment, when given a reminder call or text within 48 hours, does NOT void this fee.

____ I understand that if my check or electronic payment is rejected to NSF, there is a **$35.00 NSF FEE** added to account.

____ I am aware that my statement is sent via email. Statements that go unpaid incur a **$25.00 RESTATEMENT FEE** for each subsequent statement issued beyond 3 cycles. Fee forgiveness is possible if a payment plan is set up and honored.

____ I understand that I am responsible for any fees, expenses, and costs related to collection of any unpaid balance on my account(s). This includes any fees or commissions paid to attorneys and collection agencies.

____ In the event I/my family wishes to transfer care to another provider, I understand that my/our balance must be paid in full for medical records to be transferred or personal copies to be received within 30 days. At 30 days, records will be transferred per request and the account will go into collections if any balance remains. There is a fee for duplication of medical records per State of Illinois. I must submit a written and signed request for medical records. For continuity of care, PANACEA will fax a copy to the provider of choice at no charge.

By signing below, I acknowledge, understand, and agree to the financial policy above.

_____	_____	_____
Patient or Legal Guardian Signature	Patient Name (printed)	Date
_____	_____	_____
Legal Guardian Name (if applicable)	Witness Signature	Date