

# **Associated Foot Surgeons of Southwest Illinois, Ltd.**

## **BILLING POLICY**

I understand it is my responsibility to provide current billing information and a copy of my health insurance card(s) to Associated Foot Surgeons of Southwest Illinois, Ltd. (AFS). I must also provide my current contact information to AFS. It is my responsibility to notify this office regarding changes to my medical insurance, phone number, or address.

I understand it is my responsibility to know my insurance benefits. This includes: deductibles, co-insurance, co-pay, and general medical coverage. I understand AFS staff cannot and will not quote insurance benefits.

I understand it is my responsibility to pay my portion of the charges prior to services being rendered. I must also notify my insurance company(s) of any other insurance coverage I may have prior to services being rendered. I understand that these are contractual obligations set forth by my insurance plan. I understand my healthcare provider also has a contractual obligation with my insurance plan(s) to collect co-pays, co-insurance and deductibles at the time of service.

I understand an allowable charge will be billed to my insurance company(s) for services rendered, and I am responsible for all balances my insurance company(s) apply to patient responsibility. Non-covered services will be disclosed using an Advanced Beneficiary Notice (ABN). By signing the ABN, I agree to pay for serviced my insurance company deems a non-covered service. I further understand I have a financial responsibility to pay these amounts upon receipt of my bill. If I fail to pay all amounts due promptly, any balance due will be sent to an outside collection agency. In such an event, I understand I must pay the collection agency any balance due plus a 35% collection agency fee. I will also be responsible for any interest and legal expenses associated with collection efforts.

I understand once I have an account in collections, all balances must be paid in full prior to scheduling an appointment with AFS. I understand all future charges must be paid in full at the time services are rendered.

I understand if my payment is returned by my bank, I will be charged a non-sufficient fund (NSF) fee of the sum allowed by the State of Illinois, and all future payments must be paid with cash or credit card.

I understand I am responsible for balances due on all accounts I am listed as the guarantor, and any credit balance will be used to resolve these balances.

I understand AFS is not a provider of workers compensation, and AFS will not bill liability insurance plans. In the event my accident/injury is work or liability related I agree to pay out of pocket (self-pay) at the time services are rendered.

I understand AFS is not a Medicaid provider. In the event AFS does not accept my insurance, or is a non-provider of my insurance plan, I will be deemed self-pay and will be responsible for payment at the time services are rendered.