FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy.

ALL PAYMENTS ARE EXPECTED AT TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. Dr. Youssef accepts cash, personal checks, visa and mastercard. There is a 25.00 service fee for all returned checks.

Patients with an outstanding balance of 60 days overdue must make arrangements for payment before the patient will be seen. We realize that people have financial difficutly, therefore, we can offer a payment plan.

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at time of service. If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges.

We do not bill secondary insurance companies.

Your time of service receipt includes all the information necessary for submitting to your insurance company.

If you need assistance or have questions, please contact the Billing Office between the hours of 8:30 a.m and 4:30 p.m., Monday through Friday at 815-932-3132.

MISSED APPOINTMENTS:

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to appointment. We reserve the right to charge for missed appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand Dr. Youssefs Financial Policy. I agree to assign insurance benefits to Dr. Youssef whenever necessary. I also agree that if it becomes necessary to forward my account to collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured or Authorized representative:_____

Date: _____