Myron I. Wolf, D.P.M., FACFAS
Diplomate, American Board of Podiatric Medicine
(847) 437-7377
email: billing@wolfpodiatry.com

800 Biesterfield Road, Suite 625
Elk Grove Village, IL 60007

1585 N. Barrington Road, Suite 103
Hoffman Estates, IL 60169

FINANCIAL POLICY -- PLEASE READ BEFORE SIGNING

Thank you for choosing our practice for your foot and ankle care. We are committed to the success of your medical treatment. Please understand that a mutual financial understanding is part of our relationship.

IDENTIFICATION

Proper photo identification and street address (no PO Boxes) must be presented prior to services being rendered. Current insurance cards must be presented when services are rendered. Failure to provide accurate insurance information may result in the patient being responsible for the services rendered.

PPO/POS (Commercial Insurance)

We participate in most insurance plans accepted at Alexian Brothers Medical Center, St. Alexius Medical Center and Northwest Community Hospital. Please consult your insurance plans website or speak with our office staff to confirm our enrollment with your plan.

ALL COPAYS ARE DUE AT THE TIME OF SERVICE. NO EXCEPTIONS. If you are not sure if your plan has a copay, we will ask you to call your insurance company's customer service department prior to seeing the doctor.

WITH HEALTHCARE REFORM, MANY PLANS HAVE LARGE ANNUAL DEDUCTIBLES. This will result in a larger balance due after insurance reimburses for office services. Patient statements are mailed after we receive notification from your insurance company. Payment of balance is due upon receipt.

HMO

You will need to provide a referral from your primary care physician in order to have your insurance company cover your treatment. If you are unable to provide a referral at the time of service, you can reschedule your appointment or pay in full for the services provided.

ALL COPAYS ARE DUE AT THE TIME OF SERVICE. NO EXCEPTIONS. If you are not sure if your plan has a copay, we will ask you to call your insurance company's customer service department prior to seeing the doctor.

MEDICARE

We accept Medicare assignment. Medicare has an annual deductible and a 20% coinsurance amount of approved charges. This amount may be paid by a secondary (supplemental) insurance policy. It is important your keep your secondary (supplemental) insurance information up to date with our office. Patient statements are mailed after we receive notification from your insurance company. Payment of balance is due upon receipt.

WORKERS COMPENSATION

Patients seen for a work related injury are still responsible for all charges incurred during their treatment. All workers' compensation contact information shall be provided prior to treatment. If your employer does not pay in a timely manner, we will bill you directly.

SELF-PAY, LEGAL OR ACCIDENT CLAIMS

We will require you to pay for all treatments at the time of service.

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MINOR CHILDREN

A parent must be present in order for a child under the age of 18 to be treated. If this is not possible, an authorization form must be completed prior to the appointment time. This authorization form will give permission for another adult to accompany the child at the visit and make medical decisions for that child. In addition, the parent signing the authorization form will be financially responsible for payment. In the case of a divorce, the parent completing the intake forms will be responsible for payment.

FILING INSURANCE CLAIMS & PATIENT STATEMENTS

We will file insurance claims providing we have your current information.

PATIENT STATEMENTS are mailed after we receive payment information from your insurance company. Payment of balance is due upon receipt. In cases of hardship, we will offer short term payment plans. If a payment term of greater than 3 months is needed, we will ask you to provide a valid credit card to keep on file to automatically process your monthly plan charge. If you are unable to leave a credit card on file, we will ask you to apply for Care Credit.

A collection fee of 20% will be added to all accounts over 90 days past due without an established payment plan. After 120 days past due, your account will be placed on credit hold and appointments will only be made in the case of medical necessity as determined by our doctor. At 150 days past due your account will be forwarded to our attorney or collection agency, Allocated Business Management.

NO SHOW APPOINTMENTS/PROCEDURES & RETURNED CHECK FEE

A charge of $35.00 will be assessed for each No Show appoint. We understand emergency situations arise and appointments cannot be kept. We will review and address these situations on a case-by-case basis.

A $25.00 fee will be charged for all NSF (returned) checks.

MEDICAL SUPPLIES & DURABLE MEDICAL EQUIPMENT (DME)

If a supply can be purchased at Walgreens/Target over the counter (gauze, Coban/Co-Flex, Betadine, Biofreeze etc), it is not covered by insurance. We will not attempt to bill your insurance for these items. If you prefer to purchase the items offered at your appointment, please ask us to provide a shopping list.

Medical Supplies and DME provided at the time of service are non-refundable and non-returnable.

MEDICAL RECORDS

In order to disclose medical information, an original authorization form must be received by our office. Written medical records may be requested by another physician and faxed at no charge.

There is a charge to obtain written medical records and x-ray copies. We will use the fees established by the Illinois Comptroller's Office to determine the charges for all medical records. Please allow 4 – 6 weeks for delivery of the records.

Questions regarding this policy should be directed to our billing office.

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Patient Name ________________________________ **Date:** ____________
(Please Print)

- I have read, understand and agree to the Financial Policy of Myron I. Wolf, D.P.M./Wolf Podiatry. I have been given a copy of this policy for my future reference. I understand that charges not covered by my insurance company, as well as, applicable co-payments, co-insurance and deductibles are my financial responsibility.
- I acknowledge I have received the Privacy Notice. This privacy notice is posted in our waiting room and on our website www.wolfpodiatry.com for future reference.
- I authorize my insurance benefits be irrevocably assigned to Myron I. Wolf, D.P.M. for the services rendered.
- I authorize Myron I. Wolf, D.P.M. to release personal, financial and medical information to my insurance company to authorize treatment, facilitate treatment or payment of a claim.
- I authorize Myron I. Wolf, D.P.M. to release personal, financial and medical information to an attorney, collection agency or credit reporting agency in the event I fail to pay my account balance. I understand this information may become part of public record.
- I understand the missed appointment fee ($35.00), collection fee (20% of billed charges), and medical records fee (as determined by the Illinois Comptroller's office) as described in the Financial Policy.

I understand once I sign this agreement all terms and conditions will be in full force and effect.

Patient Signature: ________________________________ Date: ______________
or authorized guardian

Myron I. Wolf, D.P.M.
or Authorized Signature: ________________________________ Date: ______________