METHODIST MEDICAL GROUP

FINANCIAL RESPONSIBILITY

Methods of Payment Accepted: Visa, MasterCard, Discover, cash and checks. Payment of co-pays and deductibles are due at the time of service.

Individual/Group Insurance: As a courtesy to you, Methodist Medical Group will submit the appropriate claims to your insurance company(s). If your insurance requires an employee claim form, or any other information from you, please submit it to them in a timely manner. Your insurance policy is a contract between you and your insurance company. Therefore, you are ultimately responsible for payment of all charges. It is your responsibility to resolve disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, and use of any special forms. Methodist Medical Group requires that your account be paid in full within 60 days of the date of service, regardless of the status of your insurance claim. If you need an extended payment plan, please contact our Billing Office at (309) 672-4809 or (888) 772-5351

Liability: Services incurred resulting from injury or accident are considered the responsibility of the patient / guarantor. It is your responsibility to ensure that the Methodist Medical Group is paid promptly regardless of pending disputed or litigated claims. As we are unable to file claims to a third party insurance carrier, services rendered as a result of automobile accidents must be filed with your personal automotive insurance.

Medicare: Methodist Medical Group is a participating provider and accepts assignment on all Medicare claims. For your convenience, appropriate claims will also be sent to your Medicare Supplemental Insurance. Any deductible, co-payment amounts or routine non-covered services are your responsibility and will be billed to you after Medicare and your supplemental insurance has processed and paid appropriate benefits.

No Insurance Coverage: Methodist Medical Group requires payment for all charges at the time services are rendered. A self-pay discount is offered when payment is made at the time of service. If you are unable to pay at the time of service, please contact our Billing Office to make payment arrangements.

Worker's Compensation: If you are injured on the job, we will process claims to your employer in compliance with the Illinois law. If your employer or the employer's Worker's Compensation Insurance Carrier determine that your illness or injury is not related to your employment or is otherwise determined not to be covered by the Worker's Compensation guidelines, than all charges will be your responsibility.

Financial Assistance: We will be pleased to assist you with any questions regarding available payment options. Methodist Medical Group is committed to providing service to those who may need financial assistance. If you have questions regarding financial assistance or would like a Financial Assistance application, please contact our Billing Office at (309) 672-4809 or (888) 772-5351.

ASSIGNMENT OF BENEFITS

Insurance Authorization / Release: I hereby authorize the physician/provider to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any and all services rendered.

Medicare Authorization / Release: I request that payment of authorized Medicare benefits to be made on my behalf to the physician/provider for any and all service provided to me by that physician/provider. I hereby authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

My signature below indicates that I have read and understood the foregoing information relative to my responsibility for the services provided as well as authorizing the release of medical information as required to process claims and benefits to which I am entitled.

Patient Signature_____ Date: _____

Patient Name Printed: _____ DOB:_____

Patient Social Security Number:_____ Patient Acct #_____

Responsible Party: _____ Date: _____
On behalf of a minor child.

Witness: _____ Date: _____