Lake Forest Pediatric Associates
Financial Policy

Account Responsibility
When a patient is registered with Lake Forest Pediatrics, we ask that the parent or guardian seeking care accept final responsibility for payment. Patient due balances are expected to be paid within 14 days of receipt of statement. If there is an insurance dispute or financial difficulty, contact our business office at 847-295-2260 within 14 days of receipt of statement.
An account that is sent to a collection agency will be assessed a 30% collection fee. Even in divorce situations, we consider both parents responsible for the account. In the event the account is referred to a collection agency, both parents names and social security numbers will be submitted.

Payment Will Be Expected At Time Of Service When:

- Your insurance plan is one we are not contracted with.
- We are unable to verify eligibility.
- There is no insurance coverage.
- If there is new insurance and you are unable to provide an insurance card.

Co-pays
If required by your insurance plan, you will be expected to pay your co-pay **each time** your child is seen in our office. We accept cash, checks, money orders and all major credit cards.

Professional Services Rendered
If your child is seen for a scheduled preventive visit and another condition is treated at the same time, the provider will bill for each service performed.

Fees:

After Hours Phone Calls	$25
Sunday/Holiday	$21
NSF Check	$34
No Show	$25
Replacement Forms	$10

"I agree to pay for any and all medical services I receive from this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim on my behalf; however, if my insurance company refuses to pay, for whatever reason (e.g., non-covered services, does not pay for preventive medicine visits), I will pay for same upon written/verbal notice of their refusal."

"I further agree and understand that this office can only code and file a claim for my child's visit with a diagnosis that was encountered and documented in the medical record. Thus, to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and fraudulent."

"I authorize the release of any medical information necessary to process any claims, either to myself or any parties who request this information."

_____ _____
Signature of Parent/Legal Guardian Date

A copy of Lake Forest Pediatric Associates, Ltd. **Notice of Privacy Practices** has been made available to me.

_____ _____
Print Name Signature Parent or Legal Guardian Date

This receipt covers the following family members:
_____

_____ _____
LFPA Acct #