PRACTICE POLICIES

1) I am aware that I am responsible for providing SEI with current insurance information at each visit. Claims denied for insufficient/incorrect information will be my responsibility.
2) Patients must have current insurance cards and referrals (if needed) or your appointment will be rescheduled.
3) Patients are responsible for verifying insurance coverage and making sure we are a network provider.
4) Co-Pays, deductibles, account balances and refraction charges are due at the time service is rendered or your appointment will be rescheduled. I am aware that payments collected for procedures are estimates. Accounts will be reconciled after your insurance company processes the claim. You will be billed for any remaining balance.
5) We request a 24 hour cancellation notice. Failure to call and no-shows will be charged an administrative fee that is not billable to insurance. Surgery no-shows will be charged a $75.00 fee. We must have documented proof that you called our office to cancel a surgery. You must know who you talked to, the date, and the time.
6) We attempt to make courtesy phone calls to remind you of an appointment, but we are unable to provide this service at all times. Lack of a reminder call does not cancel the above no-show policy.
7) All returned checks will be charged a $30.00 administrative fee and your account will be placed on a cash only basis.
8) Invoices are due upon receipt. A $20.00 rebilling charge will be assessed on each account 60 days overdue.
9) If an account balance goes 90 days with no correspondence by you, we will assume you do not intend to pay the bill and your account will be placed for collections. If we are forced to turn your account over for collection you will be charged the collection fees which are usually 50% or the remaining balance and all other incidental fees.
10) There will be a $10.00 fee for each form that needs to be filled out by our office. Payment is due when we receive the form. There will be a charge for copying medical records. We follow the guidelines implemented by the Illinois General Assembly.
11) For prescription refills please call your pharmacy and ask them to e-scribe the request to our doctors.
12) I understand the attached optical policies.

I have read and understand the practice policies

_____	_____	_____
Signature	**Relationship (if other than patient)**	**Print Name (if other)**

_____	_____	_____	_____
Print Patient Name	**Date**	**Date of Birth**	**Social Security Number**

PHONE: You can contact me by phone at _____(home) _____(work)

Email_____ _____(cell) _____(other)