WESTGATE FAMILY MEDICINE
2015 Dean Street, Unit #2 St Charles, IL 60174
630-584-2400

FINANCIAL POLICY

Thank you for choosing Westgate Family Medicine as your health care provider. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please call our Office Manager, Judy if you have any questions. She can be reached at 630-584-2400.

This is an agreement between Westgate Family Medicine, as creditor, and the Patient/Debtor named on this form. On this agreement the words "you", "your" and "yours", means the Patient/Debtor. The word "account" means the account that has been established in your name which charges are made and payments credited. The words "we", "us" and "our" refer to Westgate Family Medicine. All patients must complete our "Patient Information Sheet" and other related forms.
By executing this agreement, you are agreeing to pay for all services that are received.

Insurance

We will bill your insurance company directly as a courtesy to our patients. We must have a copy of both sides of your current insurance card. Please notify us immediately of any changes to your insurance or coverage. If you do not have insurance or if you do not have your insurance card, full payment is due at the time of service. We accept cash, check and Visa/Mastercard/Discover.

If payment is not received from the insurance carrier or other responsible party within 90 days, we have the right to bill you directly.

Co-payments

All co-payments are due at the time of service. If your plan requires a co-pay and you present without it, ***you will not be seen.***

Collections

If your account is sent to an outside agency for collection you will be charged the 33% that is charged to us by that agency.
If we have to refer your account for collection you will be dismissed from our practice. Also, should you file for bankruptcy you will be dismissed from our practice.

Returned Checks

There is a $30.00 fee for any check returned by the bank.

Records

Two (2) weeks notice is **required** for copies of medical records. **A copying fee will be charged,** which is allowable under HIPPA and Illinois State Law. Before any records are released all balances must be paid in full, including the record copying fee and our records release form must be completed and signed.

Appointments

Patients who do not show for more than one scheduled appointment will be assessed a $25.00 fee. This fee must be paid before a new appointment is scheduled.

Self Pay

Payment is expected at the time services are rendered un less prior arrangements have been made.

Medicare

As a Medicare patient you are responsible for the difference between the approved charge and the amount Medicare pays as well as any deductible amount. If you have supplemental insurance and it is with a company we hold a contract with, we will submit the secondary claim for you as a courtesy.

HMO/PPO

We are participating providers for many, but not all plans. It is your responsibility to verify that the physician with whom you have an appointment is in your plan. If you are an HMO member you will not be billed as long as you are eligible for coverage and have the necessary referrals. We will process your referral with 48-72 hours notice.

Workman's Compensation

Workman's Compensation visits will only be allowed with the proper claim number and insurance company information. This information must be given to us at the time the appointment is scheduled.

Accident

If you are being seen as a result of an Auto accident claim, ***payment is expected at the time services are rendered.*** All billings pertaining to your auto accident will be between you and your auto insurance carrier.

Usual and Customary Fees

We are committed to providing the best treatment possible for our patients and we charge what is considered usual and customary for our specialty. If we do not contract with your insurance company you are responsible for payment in full regardless of any insurance company's arbitrary determinations of usual and customary fees.

I understand that I am entitled to ask, prior to receiving services, for the cost of the potential services. I understand that if the office agrees to bill my insurance as a courtesy that I must provide the information as needed to ensure payment for services rendered to me. ***I understand that I am ultimately responsible for the payment of all services.***

Patient's Signature _____ Date _____

Patient's Name (printed) _____