

Financial Payment

Thank you for choosing Mathers Clinic as your healthcare provider. We are committed to your treatment success. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our financial policy is necessary. Please ask if you have any questions about our fees or financial policy.

Patient Name: _____

(please print)

Initial each selection below:

FULL PAYMENT

Full payment for your copay, deductible and coinsurance is expected at the time of service unless prior arrangements have been made. Mathers Clinic accepts cash, checks, money orders and all major credit cards.

INSURANCE

We participate in several major insurance companies and mental health managed care networks. We will submit the mental health services claim to your insurance carrier if you have given us all of the required information. We will attempt to determine your benefits by contacting your insurance company via phone or online. Please note that the information we obtain from your insurance is not a guarantee of your benefits or coverage. In addition, please be aware that some and perhaps all of the services provided may be "non-covered" or deemed "not medically necessary" according to your policy.

You remain responsible for payment of any deductibles, coinsurance and copayments which are not covered by insurance for any reason. Regardless of the type of insurance coverage you have, you are ultimately responsible for paying your medical bills – even if your insurance company rejects the claim or delays payment. Since your insurance company states to us that a quote of benefits is not a guarantee of payment, it is your responsibility to familiarize yourself with your insurance benefits.

PRE-AUTHORIZATION

It is the patient's (or the responsible party's) responsibility to make certain referrals or authorizations required by your insurance company to be put in place and current prior to your appointments. Payment for any appointment kept without a needed authorization in place is the responsibility of the patient.

BILLING PROCESS

If your claim is denied, the balance due for services will be your responsibility. You will receive a statement for any amount due.

If we do not receive a response from your insurance carrier within 31–60 days of claim submission, we will submit a second claim.

If we do not receive a response from your insurance carrier within 31–60 days, you will receive a statement and will need to contact your insurance carrier regarding payment. The balance due for services will be your responsibility.

Delinquent accounts past 120 days will result in discharge from the clinic and your account will be turned over to a collection agency.

MINOR PATIENTS

The adult accompanying a minor to a visit and/or the legal parents/guardians are responsible for full payment (regardless of insurance coverage) and will be set up as the person who receives the bill and must

provide complete demographics information including both parents' date of birth and social security numbers, current address(es) and telephone numbers. Mathers Clinic will not be involved in negotiating between parents/guardians in disputes. Parents/Guardians are responsible for knowing their insurance benefits. If an adolescent patient arrives alone, please make sure that he/she has the required payment due. **Mathers Clinic will not bill third parties.**

CANCELLATIONS/NO SHOW POLICY

I agree to give 24 hours notice if I must cancel or reschedule my appointment. If I fail to do so, I understand that I will be charged \$50 for that session.

RETURNED CHECK POLICY

A \$35 returned check fee will be charged for any returned check, and the patient will be responsible for any fees for collection of past due balances.

OUTSTANDING BALANCES

I understand that **Mathers Clinic reserves the right to prohibit services to the patient if at anytime a balance of \$200 or more is accrued.** Any financial arrangements requested by the patient will be handled on a case by case basis.

AUTHORIZATION OF PAYMENT

I hereby authorize and direct payment of my medical benefits to Mathers Clinic or any services furnished to me by the staff. I also request payment of governmental benefits either to myself or to the party who accepts assignment.

COURT ORDERED EVALUATIONS (if applicable)

I understand that any court-ordered evaluations will not be released without full payment. To receive the evaluation report within 10 days from the date of completion, Mathers Clinic requires that payments be made in cash, credit card or money order. We accept personal checks, but the report will only be released 10 days after the receipt of payment.

I understand that these evaluations will not be submitted to insurance by Mathers Clinic.

I understand the above Financial Policy and agree to the conditions of such.

Signature of Patient or Legal Guardian

Date



TheMathersClinic.com

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Rockford: 6090 Strathmoor Dr, Ste 1, Rockford, IL 61107

Woodstock: 715 W Judd St, Woodstock, IL 60098

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