Northern Illinois Medical Associates

Patient Registration

Financial Responsibility Statement

CONSENT TO SERVICES:

Patient hereby requests registration at **NORTHERN ILLINOIS MEDICAL ASSOCIATES** and voluntarily consents to any facility services deemed necessary or advisable as determined by an appropriate attending physician or his/her assistants/designees, or employees or agents of **NORTHERN ILLINOIS MEDICAL ASSOCIATES** with appropriate clinical privileges. Patient acknowledges that no guarantees have been made as the result of treatments or examination at **NORTHERN ILLINOIS MEDICAL ASSOCIATES.**

PAYMENT GUARANTEE:

For any consideration of services rendered by **NORTHERN ILLINOIS MEDICAL ASSOCIATES**, patient (or guarantor) hereby agrees to and guarantees payment of all charges incurred for the account of the patient.

CONSENT TO RELEASE OF INFORMATION:

The undersigned, hereby authorizes **NORTHERN ILLINOIS MEDICAL ASSOCIATES** to release to employer groups, insurance companies, government agencies or other third-party payers and their agent's information concerning diagnosis and procedures performed, medical care, advice, treatment, supplies and other information that may be necessary for the purpose of determining eligibility and available benefits and obtaining payments on the patient's behalf for health care services rendered to the patient. Patient (or guarantor) acknowledges that he or she will be financially responsible for charges incurred for the patient's treatment if revocation or refusal to authorize the disclosure of the medical records results in a payment denial of the insurance claim.

MEDICARE PATIENTS:

Patient certifies that the information given in applying for payment under Title XVII (18) of the Social Security Act is correct. Patient requests that payment of authorized benefits made on his/her behalf. Medicare patients with secondary; Patient requests that payment of authorized benefits be made for any services furnished by **NORTHERN ILLINOIS MEDICAL ASSOCIATES**.

ASSIGNMENT OF INSURANCE BENEFITS:

Patient (or guarantor) irrevocably assigns and transfers to **NORTHERN ILLINOS MEDICAL ASSOCIATES**, all right, title, and interest to medical reimbursement benefits under any and all applicable medical insurance policies covering patients, for the payment of hospital, and medical care being provided. Patient (or guarantor) authorizes payment directly to **NORTHERN ILLINOIS MEDICAL ASSOCIATES**, of said medical reimbursement benefits.

AGREEMENT TO PAY BALANCE:

In the event that said medical insurance is not sufficient to satisfy the charge in full, patient (or guarantor) acknowledges that the resulting balance is not covered by this assignment and agrees to be fully responsible for the payment of any balance due. For any non-contracted insurance carrier, **NORTHERN ILLINOIS MEDICAL ASSOCIATES** will submit a courtesy claim and if no payment is received in sixty days, the balance will become the patient's responsibility. In the event charges are not paid, due to authorization or precertification denials, patient acknowledges the charge is considered a non-covered service and agrees to fully be responsible for payment of any balance due.

Patient (or guarantor) acknowledges responsibility for any expenses incurred by **NORTHERN ILLINOIS MEDICAL ASSOCIATES** for collecting any of the charges incurred on the account of the patient. I understand that in the event any unpaid balance is placed for collections with any 3rd party agency and/or placed with an attorney to obtain judgment or otherwise satisfy payment of this account, all collections costs, attorney fees, filing fees, interest, and court costs will be added to the total amount due.

_____ DOB _____/_____/_____ Date _____/_____/_____

Patient Name Printed

_____

Patient Signature

_____

Guarantor Signature, if other than patient

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STE 450
Sycamore, IL 60178

1750 N Randall Rd
STE 100
Elgin, IL 60123

1000 S Randall Rd
STE 225
Geneva, IL 60134

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