Greenleaf Medical Associates
401 S. Greenleaf St, Ste 1, Park City, Il 60085
565 Lakeview Pkwy, Ste 100-C, Vernon Hills, Il 60061
Ph (847)662-0978 / Fx (847)662-1395
www.greenleafmedical.com

Patient Financial Acknowledgement, Cancellation and Office Policy

______________________________ ____________
Patient Printed Name Date of Birth

Patient Financial Policy Acknowledgement
I understand and agree that **my responsibilities** are as follows:

- Charges not covered by my insurance plan, as well as applicable copayments and deductibles, are my responsibility.
- It is my responsibility to be familiar with my insurance plan and what benefits it provides. This includes what copayments and deductibles are required.

I understand and agree to the following:

- **Co-Pay:** Co-pays are due at the time of the visit. If I am unable to pay the co-pay, I understand that my appointment will be rescheduled for another time. This will result in a No Show fee.
- **Outstanding Balances:** Outstanding balances are to be paid prior to time of service. Accounts not paid may be sent to collections and can result in being discharged from the practice.
- **Self-Pay Patients:** Payment is due at the time of the visit.
- **Non-Sufficient Funds (NSF):** A $50 processing fee will be charged if checks are returned by the bank for NSF.
- **Non-Emergent After Hour Calls:** Any non-emergent calls after hours made to the provider on call is subject to a $30 fee if it is not a ***true emergency***

Cancellation Policy
In order to be consistent with our practice philosophy, Greenleaf Medical Associates uses an appointment system that sets aside ample time for a patient dependent on the patient's current needs. If you do not show up for your appointment, or notify us of your inability to keep you appointment by phone ***at least 24 hours in advance***, the time that has been allotted for your visit cannot be used to treat another patient and is time lost to our office.

Our policy is as follows:

FOLLOW UP/SICK VISIT APPOINTMENTS (15 MINUTES)	PHYSICAL/PAP/INS/PRE-OP APPOINTMENTS (30 MINUTES)	RESULT
1st Event – no 24-hour notice	-	Warning
2nd Event – no 24-hour notice	1st Event – no 24-hour notice	$50
3rd Event – no 24-hour notice	2nd Event – no 24-hour notice	$50 and discharge from the practice

If a fee is assessed, you will be required to pay the fee prior to being rescheduled. This will not be billed to your insurance.

Office Policy
We strive to render excellent medical care to you, your family and all of our patients. In order to provide you with the best care possible, we ask that you are compliant with treatment recommendations, that scheduled appointments be attended, and that you abide by the financial policy. We also ask that you and/or family members be respectful and use appropriate behavior with all staff members and other patients. Failure to abide by the above policy may result in being discharged from the practice.

It is the patient's responsibility to update their contact information (address, phone number, email) and insurance information with our office staff as soon as there is a change.

I have received, read, understood and hereby agree to this agreement.

______________________________ ____________
Signature of Patient or Legal Guardian Date

Revised 08/2017