BOLING MEDICAL, LLC
899 G SOUTH WEBER ROAD
BOLINGBROOK, IL 60490
630-226-1800
FAX: 630-226-4226
DR. SUMA KAKI, MD

Financial Policy & HIPAA

Payment is required for all services at the time they are rendered. **Office co-pay must be paid at time of service**. As a courtesy we will file your claim with your insurance carrier. Applicable co-payments, estimated deductibles, coinsurance and non-covered services will be collected. Once our office has received an "Explanation of Benefits" from your insurance, and the provider adjustments have been applied, you will receive a statement for any outstanding balance, which is due upon receipt. In the event an overpayment has been made and to ensure the most accurate refund amount, please be advised that our office cannot issue any refunds until all line items have been finalized by your insurance.

If you are a member of a plan in which you must choose a "primary care physician", it is your responsibility to select the physician you are appointed with prior to your first visit with him/her. If you have not done so, your visit may not be covered, and you will be responsible for payment in full at the time of service or you may choose to reschedule your appointment.

We accept payment in the form of cash, check, and all major credit cards. If a check is returned to our office, there will be a $35.00 return check fee added to your account. Please note that all future appointments will need to be paid with cash, credit card or money order only. For appointments which are missed or cancelled with less than 24-hour notification, there may be a $25.00 missed appointment fee added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

I have read and understand the financial policy statement. I agree to make, in-full, prompt payment to Dr. Suma Kaki at Boling Medical when billed for, any and all, charges not covered or paid by valid insurance benefits for services rendered. Further, I authorize payment directly to Boling Medical for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments.

I_____ understand that as part of my health care, this practice originates and maintains papers and/or electronic records describing my health history, symptoms, examination and test result, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment,

- A mean of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I have read, understood and agree to the terms and policy listed above.

_____ _____

Signature Date