MCSO

Metro Chicago Surgical Oncology, LLC

PRACTICE AGREEMENT

Welcome to Metro Chicago Surgical Oncology, LLC. Thank you for choosing us to participate in your health care. As you join our practice, we would like to bring the following to your attention:

INSURED PATIENTS: We will be happy to process your insurance forms as a service to you. However, we do require that you provide our office all necessary insurance information. We will require ten days to process forms.

REFERRALS: It is the patient's responsibility to obtain insurance referrals from their primary care physicians. **This must be done prior to your visit.**

CO-PAYS: Co-payments are a contractual arrangement between you and your insurance company. **Patients with insurance co-payments are required to make co-payment at the time of their visit**. There will be a **$5.00 service charge each time** if we have to bill you.

RETURNED CHECKS: There will be a $25.00 processing fee for returned checks.

NO SHOW: There will be a $40.00 charge if patient does not show or fails to cancel the appointment at least 48 hours in advance.

PRESCRIPTIONS: THERE WILL BE NO PRESCRIPTION REFILLS AFTER 4:00 PM OR OVER WEEKENDS.

MEDICAL RECORDS REQUESTS: All medical records requests require two weeks' notice to be fulfilled and an appropriate medical release filled out. There will be a **$25.00** handling fee (for persons other than patients).

WALK-INS: All patients require an appointment to be seen including laboratory testing.

CANCELATION FEE: There will be a $250.00 cancelation fee if patient cancels their in-office procedure (biopsies, fusion biopsies, vasectomies, cystoscopies, urodynamics) less than 36 hours in advance of the scheduled procedure and a $500.00 cancelation fee for all surgeries (in hospital procedures) 48 hours prior to the surgical procedure.
I have read this agreement and fully understand its contents. I understand that my insurance will be billed, but I am responsible for all charges, deductibles, and co-pays in the event that my insurance denies the charges. I have received a copy of this agreement.

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Print Patient's or Responsible Party's Name	Date
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Patient's or Responsible Party's Signature	Date