Koch Family Medicine, S.C.
411 Maxine Dr
Morton, IL 61550
Ph: 309-263-2411

PAYMENT POLICY

Thank you for choosing Koch Family Medicine. We are pleased to be of service to you during your time of need. Our business policy is as follows: All charges for service are the responsibility of the patient or their guardian. Payments may be made by Cash, Check, Visa, or MasterCard.

Office Visits:

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Payment is expected at the time of service. You will receive a "super bill". You will be required to pay your co-pay or your deductible amount or full amount depending on your coverage. Patient is responsible for all legal fees, collection costs (typically 33-50%) of the balance, court costs and attorney fees that result from not maintaining account within the terms granted.

Managed Care:

We are under contract with Managed Care Plans. Please consult your provider directory for verification of our participation. You will be responsible for any ***deductibles and co-payments at the time of service.*** Claims will be submitted based on your policy guidelines. It is the patient's responsibility to provide primary care authorization and pre-certification requirements.

Medicare:

We will bill medicare directly. You will receive an EOB from Medicare. You will be responsible for your deductible and co-payment amount.

Work Related:

If your injury or illness is work related, we request that you provide our office with written verification of your worker's compensation coverage. You must obtain this information by contacting your employer or their insurance carrier. Verified worker's compensation coverage will be billed directly to your employer. Balances over the usual and customary are the responsibility of the patient. If claim is not settled in a timely manner, the patient will be responsible for payment in full.

Accident related:

If your injury is the result of an accident, or you are pursuing a personal injury suit, please provide our office with all third party policies and your attorney's name and address. We will provide information upon request to the appropriate party, however payment is the responsibility of the patient.

No Insurance:

If you do not have insurance coverage, payment is required at the time of service.

Thank you in advance. Koch Family Medicine

Patient Signature:_____ Date: _____

Patient Name (Please Print): _____Birthdate: _____