Maciej Drazkiewicz, M.D
Hematology and Oncology
Certified by the American Board of Internal Medicine

2222 W Division St
Suite 215
Chicago, IL 60622
(773) 227-8807

1022 N Northwest Hwy
Park Ridge, IL 60068
(773) 227- 8807

3929 N Central Ave.
Suite 1
Chicago, IL 60634
(773) 227-8807

FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept cash, checks, Visa and MasterCard.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor-if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a payment from your insurer, we will refund any overpayment to you.
3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment, co-insurance at the time of your visit.
4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.
5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.
7. Many Medicare replacement policies may require an authorization/referral from your primary care doctor. If we are out of network and your policy doesn't have out of network coverage you are responsible for the cost and payment is required at the time of the visit.

   I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at the disclosure of the practice.

_____ _____
Signature Date

_____
Please print the name of the patient