Proponent Ear, Nose, and Throat, S.C.
2350 Royal Boulevard, Suite 500
Elgin, IL 60123
Phone: 847-697-3800
Fax: 847-697-3804

Payment Policy

Thank you for selecting our medical office for your medical services. We take pride in providing you with quality medical care.

In the past, our patients have worked with us to help keep costs down by paying for our services as they are provided. We would appreciate your cooperation with our payment policy. We will bill your primary insurance and secondary insurance if you give a copy to us at the time of service.

Patients who have no insurance must pay in full at the time of service.

We accept cash, check, MasterCard, Visa, and Discover Card.

You are responsible for your co-pay at the time of service. Any balance due after your insurance company's payment must be paid in full within 45 days.

A payment plan may be arranged when necessary.

Any account that has become unreasonably delinquent will be assessed a $2.00 monthly billing fee. Additionally, you will be responsible for any and all costs of collection for unpaid balances, including, but not limited to collection agency fees, reasonable attorney's fees, and court costs.

A fee of $50.00 may be charged to your account for cancellations not made at least 24 hours in advance.

Please be aware that certain in-office procedures may be classified as "surgery" by insurance carriers and are subject to a charge separate from the office visit. Examples include nasal endoscopy and flexible laryngoscopy.

Also, please be aware that there is a charge for follow-up visits that the doctor may have recommended to further assess your condition, review test results, or to see if the doctor's recommendations and treatment has helped your condition.

If you have had surgery, then, depending on the surgery, there may be a global period in which the office visit is included. Additional procedures performed after surgery may be billed separately.

If you have any questions about this, please ask one of the staff.

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- ✓ I have read the Payment Policy and I understand and agree to this policy. I also understand that it is the patient's and family's responsibility under the Illinois Family Expense Act to pay for all services provided.

- ✓ I authorize Proponent Medical Group, LTD., to release any information acquired in the course of examination or treatment in order to process insurance claims on my behalf. I permit a copy of this authorization to be used in place of the original.

- ✓ I hereby authorize Proponent Medical Group, LTD., to apply for benefits on my behalf for services rendered by them. I request that payment from my insurance company be made directly to Proponent Medical Group, LTD., or the party who accepts assignment.

- ✓ I certify that the information I have reported with regard to my insurance information is correct. I permit a copy to be used in place of the original.

SIGNATURE _____ DATE _____