

# Dr Allen Kuo

Selah Healthcare Professionals

1000 Hart Rd, Ste 130

Barrington, IL 60010

## Shortcut Policy Checklist

To highlight some of the more important items please review this checklist in detail and when fully read please sign at the bottom. It is still encouraged for you to review the whole policy and procedures.

- Canceled or changed appointment times within 24 hours of your appointment are subject to a \$25 fee which insurance will not pay.
- Missed appointments are subject to \$125 no show fee which insurance will not pay.
- Self pay, copays or deductibles are **DUE** at time of service.
- **ALL** telehealth patients are required to leave a means of valid payment on file such as a Credit or Debit card in order to cover payment.
- Patients with balances overdue by **90 days** must make payment otherwise services will not be rendered.
- It is **YOUR** responsibility to pay any unpaid balances or work out any insurance issues you might have with your insurance company. Our staff will **NOT** call your insurance company for you.
- Documentations ( letters, forms, disability paperwork), prior authorizations and genesight results might incur a charge at the discretion of our office. Charges will be discussed with you before incurred. Please allow 5-7 business days to complete.
- Please check with your pharmacy **BEFORE** calling the office for prescription refills.
- Pharmacy requests made on the emergency line, during weekends and non business hours **WILL** incur a \$25 fee which insurance will not cover.
- Please show courtesy to our staff and physicians. It is our attempt with the high volume to serve your requests as best as we can. If courtesy is not shown, then we reserve the right to dismiss you from the practice.
- If your prescriptions have been denied at the pharmacy, it is most likely you are due for a follow up. It is your responsibility to make timely follow up appointments in order for us to administer the best care we can. Federal Law requires that timely follow up appointments are made.

I have read the above thoroughly and agree to all of the above in order to be treated by Dr Kuo.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

