George Kuefner MD RPVI
Board Certified ABVLM, Phlebology /Vein Disorders
14482 John Humphrey Dr.
Orland Park, IL 60462
708-460-8800

Office Policies

Insurance

Our practice participates in most insurance plans. We routinely submit requests for pre-determination of benefits to your insurance carrier to maximize your benefits and allow you to estimate your insurance coverage. Dr. Kuefner participates with BlueCross/BlueShield PPO, Cigna PPO, Medicare, most Union Plans, BlueCross FEHP, Cigna FEHP, CPS, City of Chicago Plans and most Municipal Plans. Dr. Kuefner does not participate with Medicaid, HMO plans or United Healthcare Plans. If you are unsure about your insurance coverage, we recommend that you call your insurance plan customer service department to confirm your coverage and eligibility.

Deductibles and Co-pays

As a courtesy to our patients, we file insurance claims with companies that we are contracted with. You will be asked to pay your balance (co-pay/deductible/coinsurance) following each processed insurance claim/payment for services rendered. You will be billed based on your contractual agreements with your individual insurance company. All balances are payable within 30 days upon receipt of billing statements. Our accounts are reviewed regularly and collection determinations are made monthly.

Accepted forms of Payment - Cash, Check, All Major Credit Cards and Debit / Bank Card.

No-shows and Cancellations

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you and accommodate those patients who are waiting for an appointment. As a courtesy to our office please give us at least 24 hours notice. After three no-show appointments, our practice may decide to terminate its relationship with you.

Please check which treatment you are seeking

_____ I am seeking evaluation and treatment for medical purposes and have a health insurance plan Dr. Kuefner participates with. I authorize assignment of insurance benefits directly to Dr. Kuefner for services rendered. I understand that I am responsible for any charges incurred that are not covered by my insurance for any reason. I will cooperate with the office or billing service for any unforeseen issues regarding my insurance.

_____ I am seeking treatment for cosmetic purposes. I am here for a complimentary cosmetic consultation.

_____ I do not have health insurance or belong to an insurance plan that Dr. Kuefner does not participate with. I will pay the office directly for my medical evaluation and treatment.

Print Name_____ Date _____/_____/_____

Sign Name_____