**Laura Ragauskaite, M.D., F.A.C.S.**
Board Certified Surgeon

**Reza A. Gamagami, M.D., F.A.C.S.**
Board Certified Surgeon

**Venkata R. Kakarla, M.D., F.A.C.S.**
Board Certified Surgeon

**Erik Borncamp, M.D., F.A.C.S.**
Board Certified Surgeon

**Jennifer Clark, PA-C**
Physician Assistant

**Daniela Jurevicius, PA-C**
Physician Assistant

**Shabir Abadin, M.D., M.P.H., F.A.C.S**
Board Certified Surgeon

**NEW PAYMENT POLICY (PLEASE READ IN ENTIRETY)**

Progressive Surgical Associates has implemented a new policy for all patients. If you wish to be seen by our practice, we will be requesting your credit/debit card information to keep on file to be used to cover any charges not paid by your insurance. Patients will still be expected to pay known co-pays, co-insurance and any applicable deductible at the time of service. If a balance remains after your insurance has paid, you will receive two statement for services, mailed on the 1st and the 15th of the month. Payment is due 30 days from the first statement.

It will be the responsibility of the patient to contact our office if there is any question regarding your claim, amount due, to set up a payment plan, or provide an alternate form of payment before 30 days from the first statement. If we do not hear from you within 30 days of the first statement, the balance on your account will be charged to your credit/debit card on file.

Your credit/debit information will be kept with the highest level of security and will only be used for your medical expenses.

Your understanding of and patience with this new policy is very important. To be clear, no charges will be placed on your credit card until after your claim is settled with your insurance carrier and a statement has been mailed to you. If we do not hear from you within 30 days after the first statement statement has been sent, we will charge your credit card.

Patient's Name: ________________________________ Date of Birth ____/____/______

Cardholder's Name:_____________________________

Card Type: ____Visa ____ MasterCard ____ Discover ____American Express

Credit Card Number: _________________________________________________

Expiration Date: _____ / _____ CVV: _______ Billing Zip Code: __________

Signature: ____________________________________ Date: ____ / ____ / ________

Credit/Debit Card Consent Form

My signature above authorizes Progressive Surgical Associates to maintain my credit/debit card information to be used for charges that are my responsibility, after insurance has paid their portion. I understand that this form is valid until I provide written notice that it is revoked (after any balance is paid in full). I also understand that if I change to a new credit/debit card, I will supply Progressive Surgical Associates with the new credit/debit card information.

1890 Silver Cross Blvd. Ste. 410 New Lenox, IL 60451 Phone: (815) 717-8730 / Fax: (815) 717-8729 www.gamagami.com