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The Women's Group of Northwestern
OBSTETRICS AND GYNECOLOGY
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Financial Policy Guidelines

Welcome to The Women's Group of Northwestern. We strive to provide you with excellent medical care and our goal is to make your visit as convenient as possible. Please read our financial policy and if you have any questions please ask one of our staff for assistance or call our billing office at (888) 318.2788.

By signing below you confirm that you have read this policy and understand your obligations:

Please remember to bring your current insurance card(s) to each visit. This allows us to verify the information and assist you in collecting the appropriate benefits from your insurance company.

MISSED APPOINTMENTS/LATE CANCELATIONS

Missed or cancelled appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside to you. Rescheduling and/or cancellations are requested 24 hours prior to the appointment. We reserve the right to charge $75.00 for these missed appointments that are not cancelled accordingly.

INSURANCE POLICIES

For insurance companies with whom we participate:

We are pleased to submit your insurance claims for you. On the day of your visit, if your insurance company requires a co-pay, coinsurance, and/or deductible, this needs to be paid at the time of service. In addition, you are responsible for any and all charges that your insurance does not cover.
If your insurance company has not processed your claim within 30 days of receipt, you may be responsible for full payment. We request your assistance in following up with your insurance company to resolve any non-payment issues. Payment will be processed on your credit card on file.

It is your responsibility to keep WGNW up to date with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment for the visit or procedure.**

For insurance companies that we do not participate with:
We are happy to assist you in submitting your insurance claim. However, you will be expected to pay our full charge on the day of your visit. Your insurance company will then pay you directly for the portion of the bill that they may determine is covered.

SELF PAY
If you do not have insurance or are seeking care outside of your insurance plan benefits, payment in full is expected at the time of service. Our staff will gladly give you a cost estimate prior to your visit. If you are interested in making arrangements please contact our Billing Department at (888) 318.2788.

COPAYMENTS
According to the agreement that you have made with your insurance company, copayments are due at each visit. If you are not prepared to pay your co-pay, your appointment will be rescheduled.

COINSURANCE
Coinsurance is based on the pre-determined level of coverage outlined in your insurance policy. For example you may have an 80/20 plan, meaning the insurance company will consider and pay on 80% of the charges and the remaining is the patient's responsibility. It is important that you review your coverage to understand your level of coverage and financial responsibility.

COORDINATION OF BENEFITS:
If you are covered by more than one insurance plan please provide us with the secondary insurance when you schedule an appointment. If you have other insurance and fail to provide this information at the time of service it will affect the processing of your claim. If your insurance withholds claim payment due to any coordination of benefits matter, you will automatically be responsible for all charges.

DELIVERY AND PROCEDURES
Our staff will contact your insurance to verify eligibility, determine benefits and any possible "out of pocket" costs. Any patient responsibility will be due prior to your delivery and/or procedure. For your convenience, payment arrangements are available. Please contact our Billing Department to set up a payment plan. *This verification of benefits is only an estimate of what you may owe and NOT a guarantee that your insurance company will make payment.* Please call your insurance company if you have any questions.

LABORATORY

Due to varied contractual arrangements between lab companies and health insurance plans, certain insurance plans require you to use a specific lab. Please verify that our current lab, Quest Diagnostic or Northwestern Memorial Hospital, are covered by your insurance company. Your lab billing may at times be separate from our physician billing and you may receive a separate itemized bill from the laboratory. *Please contact the laboratory regarding any billing questions.*

CODING FOR YOUR SERVICES

Many insurance companies restrict the type of services that are covered by their policies. It is your responsibility to know these limitations. WGNW cannot charge for services based on the limitations of your insurance policy. Government regulations dictate that all health care providers must submit claims that accurately reflect the services that are provided. Based on these regulations, if you are seeing us for preventative services, but at the same time encounter additional problem-related issues, there may be an additional charge for these services. These additional services may or may not be covered by your insurance company. We are unable to change coding when it accurately reflects the services you received. Please consider scheduling a separate visit for problem related discussions. Reserve separate time for your annual preventative health exam.

FEES

Our fees for professional services are consistent with those in the community. An estimate for proposed services may be obtained upon request. We suggest you contact your insurance prior to services being rendered so that you are aware of your potential financial responsibility. It is the patient's responsibility to know and understand your plan coverage and benefits. If you have any questions regarding our fees, we encourage you to discuss them with our Billing Representatives at (888) 318.2788.

DISABILITY AND OTHER FORMS

We realize that special forms are sometimes necessary to provide documentation of medical conditions. Completing forms is time consuming and generally falls outside of the contractual relationship between you and your insurance company. We will be happy to complete your form. A $25 fee will be charged for each form. Please allow 7-10 days for your request.

RETURNED CHECKS

A fee of $35.00 for checks returned to us for insufficient funds will be charged to your account. Future services will require payment by cash, money order, or credit card for your payment obligations.

BALANCES

All balances must be paid in full prior to being seen by a physician. Failure to make this payment may result in your appointment being rescheduled.

STATEMENTS

You will receive a statement from our Billing Department twice a month if there is an outstanding balance. The billing statement will itemize services as well as any payments, deductibles, or coinsurance

amounts applied by your carrier. Payment is due within 7 days of receiving the statement. It is important to pay the balance within this time frame to avoid additional collection action. If you do not understand your statement or have questions regarding your balance, please feel free to contact our Billing Department at (888) 318.2788 for clarification. If your insurance delays processing or processes your claim incorrectly, you will need to contact them directly. If you cannot meet your financial obligation, please contact a Billing Representative. Every effort will be made to work out an acceptable payment plan. You will continue to receive a statement until all of your charges and all dates of service are paid in full. For your convenience Checks, Visa, MasterCard, Discover and American Express are accepted. For your convenience you can make prompt on-line payments on our secure portal. Visit our secure Patient Portal to make your payment.

PAST DUE ACCOUNTS

In the event that a balance becomes past due, the account will be considered delinquent. Delinquent accounts are subject to further collection action, including placement with a collection agency. If your account is referred to an outside collection agency, you will be responsible for all cost incurred in the collection of said balance which will also include an additional agency fees of up to 26% of your outstanding balance, a $35 account placement fee, court cost and attorney fees.

AFFORDABLE CARE ACT:

In the event WGNW is notified by your Insurance Company that you have entered into a Grace Period for non-payment of your insurance premium, you will be asked to pay 80% of the allowable amount for services rendered on the date of service. You will receive a refund after WGNW has verified that your premium is current.

ASSIGNMENT OF BENEFITS:

I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered directly to the Women's Group of Northwestern. I hereby authorize the Women's Group of Northwestern to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered under my insurance plan.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in management of your account. If you have any questions about the above information, please do not hesitate to ask us. We are here to help you.

Payment Authorization Form

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.
2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.
3. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.
4. I agree to provide the above practice and/or its designated payment agent with my debit/credit card or electronic check payment (ACH) information.
5. I understand that my signature and payment information will be maintained on file digitally for future use by the practice. The applicable payment card or checking account information will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information. Card or electronic check payment (ACH), Information will be obtained through a card swipe, manual entry from card, void check, or orally in person or over the phone.
6. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I can avoid interest charges by paying my bill immediately if required or by its due date.
7. I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or electronic check payment (ACH) account for all amounts owed to the practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.
8. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance.
9. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.

_____ (Initial) I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

_____ (opt out) I prefer my statements to be mailed to me.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

_____ _____

Name as it Appears on Card/Checking Account Email Address

_____

Phone Number

_____

Billing Address City State Zip Code

AUTHORIZED SIGNATURE _____ DATE _____

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