The Women's Group of Northwestern
OBSTETRICS AND GYNECOLOGY
www.womenobgyn.net

FINANCIAL POLICY AUTHORIZATION

I understand that all charges incurred are my personal responsibility. I authorize payment for services rendered to me to be paid directly to my Physician(s), and if correct information is supplied at the time of visit, that managed care insurance is filed with the contracted carriers. I understand that I am responsible for all residual balances, including but not limited to co-pays, deductibles, coinsurance, and charges not paid or covered by insurance for any reason, after consideration of contractual adjustments. There will be a $10 fee for not paying the above-mentioned balances at the time of service.

If your insurance company does not pay in full within 90 days, the balance that is due becomes your responsibility to obtain payment from your insurance company. We will assist you in any way, but the balance WILL be transferred to you and remain on your side until the claim is paid.

Obstetrical patients with commercial insurance are required to pay any co-pays/deductibles/coinsurance by 28 weeks gestation. Other services not covered as part of the global obstetrical care are due and payable at the time services are rendered.

Surgical patients are required to pay their deductible and coinsurance amounts PRIOR to their scheduled surgery date unless otherwise stipulated by contract with a managed care insurer.

Self-Pay patients, or patients seeking care outside of your insurance plan benefits, are expected to make payment in full at the time of service.

This facility requires a credit card to be kept on file within our secure and compliant database. If a required payment is not received within seven days of the statement date, payment will automatically be initiated to the card on file. I authorize any payment due, up to but not more than $200, for any outstanding balance. If I decide to use a different payment method or payment plan, I will immediately call the office with a different form of payment, no later than seven days from the statement date. I understand that I am responsible for paying this balance as indicated to avoid paying additional statement fees or interest on the balance.

I authorize this practice to send Electronic Account Statements and invoices to my email address on file.
____Yes (E-Statements)/____No (Paper Statements) Email Address:_____

I agree to pay 35% of any unpaid balances, as collection fees, if my account is turned over to a collection agency. I further agree to pay reasonable attorney fees and cover costs arising out of any litigation concerning the collection of this account.

I acknowledge that I have fully read and understand all of the terms and conditions, as well as any charges and payment terms associated with this contract, and hereby agree to be bound by all of the above terms.

Common Fees:

NSF (Returned Checks):	$35.00 per occurrence
No Show (without 24-hour notice):	$75.00

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Patient Signature (or Legal Guardian for Minors) Date