The Northwestern Specialists For Women

900 N Kingsbury Road, Ste 130N, Chicago IL, 60610. phone: 312-775-1100

The Northwestern Specialists for Women Financial Policy

Thank you for choosing services at The Northwestern Specialists for Women, we are committed to providing you with the best possible care. If you have medical insurance, we can assist you in receiving your maximum benefit. In order to achieve these goals, we need your cooperation and your understanding of our payment policy. The following is a summary of our financial policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE!

Payment is required at the time services are rendered. This includes co-payments and co-insurance for participating insurance carriers. NSW accepts cash, personal checks (instate only), money orders, Visa or MasterCard. It is a requirement that your credit card information be retained on file. No charges will be made without your notification. We understand your concern providing us with this sensitive information and we will respectfully keep this information confidential.

There is a service charge for all returned checks; we will charge one of the following fees to the credit card on file.

- $30.00 for NSF plus the amount of the check
- $50.00 for Closed Accounts plus the amount of the check

Patients that are self-pay are expected to pay the full amount at time of service.

Insurance carrier

ILLINOIS STATE LAW requires insurance carriers to pay claims within 30 days of receipt. Insurance carriers who fail to comply with these state standards are subject to additional requirements and penalties. Your insurance is a contract between you, your employer and the insurance carrier. We will bill participating insurance carriers as a courtesy to you. It is your responsibility to contact your insurance carrier to make sure that your provider is contracted with your plan/network. You must present all updated insurance information at time of service.

If we have not received payment from your insurance carrier within 60 days of the date of service, you will be expected to pay the balance in full or make payment arrangements prior to scheduling any future appointments. Our process will include a charge to your personal credit card for any outstanding balance beyond 61 days.

If our office does not participate in your insurance plan, you are responsible for the full balance. As a courtesy we will file a claim on your behalf, however, 30% of the claim

needs to be paid prior to submission. If your insurance company submits payment to our office, we will promptly credit your account or you will reimbursed.

We strongly suggest monitoring your account with our practice and your insurance carrier as it ages beyond 30 days. Please contact our **billing office 312-775-1100** at any time during normal business hours.

Keep in mind the following when speaking to your insurance provider representative:

- Identify the date of service for the unpaid claim
- Record and retain the date you called your carrier
- Record and retain the name of your claim representative
- Identify and correct the problem causing the payment delay
- Verify that your insurance provider has the appropriate billing information including;
- Full name of insured
- Complete address of insured
- Guarantors name for the policy
- Social Security number for the guarantor
- Correct billing address for your policy
- Insurance policy number
- Retain any reference numbers given

Be sure to ask the claim representative when you can reasonably expect reimbursement and follow-up with the same claim representative if you haven't received timely payment.

MISSED APPOINTMENTS/LATE CANCELLATIONS:
Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Rescheduling and/or cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for these missed appointments.

- $50.00 fee late cancellations/no-shows
- $25.00 fee excessive rescheduling (More than two consecutive appointments)

Excessive abuse of re-scheduled and or canceling appointments may result in discharge from the practice.

PREAUTHORIZATION:

It is your responsibility to know if your insurance company requires preauthorization for treatment (i.e. labs, ultrasound, and procedures). We will assist you in the process by providing you with the necessary procedure/diagnostic codes. Please check your benefits prior to having any of these services done in our office. If you decide to have diagnostic services or labs performed in the office, you will be responsible for any charges not covered here by your insurance carrier.

MEDICAL RECORDS REQUEST:

If you need to obtain a copy of your medical records, you will need to complete a medical records release form. There is a fee for all medical records/labs/ and chart note requests. Your signature on the release form authorizes us to include all relevant information, including your payment history. Processing of medical records takes 5 business days.

- Handling charge $23.80

- Copy pages 1 through 25 $.89

- Copy pages 26 through 50 $.59

- Copy pages in excess of 50 $.25

There will be a delay in processing of medical records if your balance is greater than $50.00. During that time NSW will assist you in resolving your balance.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF MEDICAL BENEFITS:

I have read and understand the Northwestern Specialists for Women Financial Policy.
I authorize the release of medical information necessary to process insurance carrier claims for treatment. Photocopies of this are valid as the original. I authorize medical benefits to be directly paid to NSW.
I understand that I am financially responsible for any treatment not covered by my health insurance carrier.
I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for the cost of collections.

_____ _____
Print Name of Patient Print Guardian Name

_____
Patient Date of Birth

_____ Date _____
Signature of Patient or Guardian

Credit Card information:

Name of card holder _____ _____ _____
Last First MI
Name of Patient (please Print) _____ _____ _____
Last First MI
Name of Card _____Visa _____ MasterCard

Card Number _____

Exp. Date: _____/____ CVV# ____ (3#'s located on back of card)

Authorized signature: _____

Billing Address _____

Home Telephone: _____ Work Telephone: _____

Patient Account Number: _____ Employee Initials _____