NORTHWESTERN CHILDREN'S PRACTICE

I, ____________________, authorize *The Northwestern Children's Practice* to charge my credit/debit card for the following:

____ (initial here) Copayment due at time of service.
____ (initial here) *After hours consultation:* $30 for telephone advice when the office is closed.
____ (initial here) *Missed appointments:* $50 (per child) for failure to notify us more than 24hrs prior to the visit.
____ (initial here) *Health/Camp Forms:* $10 per child for forms not presented at the time of an office visit.
____ (initial here) *NSF Checks:* The amount of the check plus $35 for returned checks.

I realize that it is my responsibility to determine whether my provider at *The Northwestern Children's Practice* is a participant in my insurance plan. I accept the financial responsibility to register my child with my insurance company and provide my insurance company with the necessary information such as coordination of benefits. I accept the responsibility to notify the office of any changes of insurance, home address and primary telephone number.

I accept the responsibility to determine my insurance information such as patient responsibility, maximum benefits, covered benefits, deductibles, copays and the status of my account and I agree to pay the copays deductibles, and balances due of all the charges not paid for by my insurance coverage.

Printed Child's Name(s): ______________________________ D.O.B.: ____________________

Cardholder Name: ______________________________

Signature of Cardholder: ______________________________

Credit Card Number: ______________________________

Exp date: ______/______ CCV Security Code: __________ Zip Code: __________

Email: ______________________________

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