
# Financial Policy

The Association for Women's Health Care, LTD is committed to providing the highest quality of care to you. As part of your relationship with us a clear understanding of our financial policy is important so you will know what actions we will be undertaking on your behalf as well as what your financial responsibilities are.

## Health Insurance

Your health insurance policy is a contract between you and the insurance company. You have certain responsibilities to ensure that proper, accurate and timely submission of charges occurs. You are required to:

- Present your insurance card at the time of each visit
- Present a picture ID (driver's license preferred) for verification of identity
- Inform us of any insurance carrier changes and provide us with a copy of the new card. We will need a copy of the front and back of the card.

## Patient Responsibility

- Co-Pay – Your health insurance policy may state that you must pay a copayment for physician visits. This payment is due at the time of check-in. The Association for Women's Health Care, LTD has a contractual agreement with your health care plan to collect your copay on the date the services are rendered. We accept cash, check, Visa, MasterCard, American Express and Discover
- Balance after Insurance – The Association for Women's Health Care, LTD will file your claim to your insurance carrier for all services rendered. Once the insurance company has process your claim we will post any payment and contractual adjustments to your account. If there is a remaining balance, the balance is now your responsibility. This balance may include your deductible, co-insurance and all non-covered services. We will send you a statement showing what is due. All payments are due within 30 days of the statement date.
- Non-Covered Services – There are some services offered by the Association for Women's Health Care that may not be covered by insurance, not considered medically necessary by your insurance company. Your physician, however, considers these necessary for your treatment. You are still responsible for payment of treatment regardless of The Association for Women's Health Care's contract status when it comes to non-covered services. Some common examples may include physical therapy, ultrasound, contraception, infertility and some vaccines.

## Cancellation Policy

All cancelled appointments (doctor, physical therapy, ultrasound, nurse, etc.) require at least one business day advance notice of the scheduled appointment day. This allows us to accommodate other patients seeking appointments. Appointments cancelled without sufficient notice or no shows will be subject to a fee of $50.00

**Credit Card Payment System**

We are pleased to announce that we offer a credit card payment system. We ask that you complete the appropriate form so that we may charge your credit card for your patient responsibility portion as listed above. See the form for details.

**Online Bill Pay**

We offer the convenience of online bill pay. Please go to www.chicagoobgyn.com to pay your bill online.

**Non-Payment on Account**

The Association for Women's Health Care, LTD will make every effort to communicate with you about your account and will present reasonable options for payment. In the event the bill goes unpaid, after 90 days, your account will be turned over to collections. If your account is sent to collection a charge of 35% of the amount due will be added to the balance of your account.

**Certificate of Insurance**

I certify that I am covered by the insurance provided and I assign directly to The Association for Women's Health Care, LTD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance on file. I hereby authorize The Association for Women's Health Care, LTD to release all information necessary to secure the payment of benefits.

_____ _____

Patient Name Date

_____ _____

Patient Signature Date

I have read the above financial policy and I agree to the terms listed.

_____ _____

Patient Name Date

_____ _____

Patient Signature Date