

**Women's Medical Group
div. of Midwest Center for Women's Healthcare
64 Old Orchard Center
Suite 200
Skokie, IL 60077
Tel. (847) 673-3130**

FINANCIAL POLICY

Thank you for choosing Midwest Center for Women's Healthcare (MCWH) as your health care provider. We are honored by your choice and committed to giving you high quality care. Please understand that payment of your bill is part of your treatment and read and sign the following agreement prior to initiating treatment.

The responsibility of paying for any treatment is always the responsibility of the patient (or the guardian for a minor). "Third party payers" such as Medicaid, Medicare, or insurers, may also contract for responsibility for medical services. Patients with an HMO or PPO plan are responsible for co-pay, deductibles, co-insurance, and all other procedures not covered by their health plan. It is your responsibility to provide accurate and up to date insurance information; if we are provided incorrect information you will be responsible for all charges.

Payment is due at the time of service: we accept cash, check, and most major credit cards. Patients who have a health plan can elect to use their coverage as part of their payment and we shall file their claims directly to the insurance company. However, the patient must pay the estimated remainder of the bill at the time of treatment unless special arrangements have been made prior to treatment.

Some of our miscellaneous charges are:

- **\$25 fee for all returned checks.**
- **minimum \$25 fee for all appointments that are missed without a 24 hour notice**
- **minimum of \$30 fee for after office hours consultation phone calls requiring diagnosis, treatment, or refills of existing prescription**
- **minimum \$30 fee for consultative phone calls during office hours**

If you plan to use a third party payer (i.e. insurance) we need the following release to allow us to process claims with you insurance:

I hereby authorize MCWH and the physicians, staff, and hospitals associated with MCWH to release as may be required, such medical and other information to the necessary insurance companies, employer groups, or other health plans, under which coverage may be available, for the purpose of obtaining reimbursement of expenses allowable under Medicare, Medicaid, or any other health plan which I may be entitled to reimbursement.

I also authorize assignment of financial benefits directly to MCWH and any associated medical personnel for services rendered as allowable under standard third party contracts. I understand that I am financially responsible to MCWH and the physicians associated with MCWH for charges not covered by this assignment.

I also authorize communication by mail or answering machine message by MCWH personnel at the address and telephone numbers listed in my registration information.

I have read, understand, and agree to the provisions of this Financial Policy.

Signed _____ Date _____
(signature of person financially responsible of the bill, Patient or Guardian)

Waiver of Financial Policy:

I do not wish to have this information released and prefer to pay at the time of service and/or to be fully responsible for the bill and to submit claims to insurance at my discretion.

Signed _____ Date _____