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## **The Women's Practice Payment Policy**

Due to recent changes in many patient's insurance coverage, reimbursement and co-payments, we want to take this opportunity to clarify the payment policy of The Women's Practice.

1. Payments of copays, patient portions and balances are due at the time of services rendered.
2. If an appointment is not cancelled within 48 hours in advance a \$50.00 charge will be made. Your credit card will be automatically charged for this missed appointment fee.
3. After your insurance carrier pays its portion of your claim, you may be responsible for a patient portion. This patient portion is possible if copays, uncovered services or unmet deductibles occur. We will notify you in writing of your portion, which is due for services provided. You will have **30 days** from the billing statement to provide payment for these charges.
4. Our billing department will submit a claim for services rendered for you in our office on a specific date. Insurance carriers are required to pay their portion of your claim **within 45 business days** from receipt. We will do everything we can to provide thorough and adequate information to your insurance company to allow prompt and accurate payment.

However, if your insurance carrier delays or withholds payments for more than 90 days from the services rendered you will be held responsible for all payment due for the date of service. If you do not provide payment directly, your credit card on file will be charged for the services due.

If we subsequently receive a payment from your insurance company, we will credit your account or provide a refund to you for the amount of the payment received.

We strongly suggest that you monitor your account and the explanation of benefits forms that you will receive from your insurer. If there is a dispute, please contact your insurance company directly. If you have additional questions feel free to contact our billing department with questions or comments, at 312-751-7515.

I acknowledge the information in The Women's Practice payment policy has been read and understood.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Credit Card Authorization

I give The Women's Practice permission to charge my credit card for outstanding balances, copayments due, patient portions of services rendered and missed appointment fees, as described in the payment policy provided in this document.

Name of Patient: \_\_\_\_\_  
*LAST* *FIRST*

DOB: \_\_/\_\_/\_\_\_\_

Type of Credit Card:  Visa  Mastercard  AMEX  Discover

Card Number: \_\_\_\_\_-\_\_\_\_\_ - \_\_\_\_\_-\_\_\_\_\_

Billing Address: \_\_\_\_\_

\_\_\_\_\_  
*CITY* *STATE* *ZIPCODE*

Name of cardholder: \_\_\_\_\_  
*LAST* *FIRST*

Authorized Signature: \_\_\_\_\_

Date: \_\_/\_\_/\_\_\_\_