



1555 N. Barrington Rd.  
Suite 410, Dr. Bldg 1  
Hoffman Estates, IL 60169-1063

**FINANCIAL POLICY**

Elite Women’s Care is committed to providing the best possible care, and we understand your need to plan for associated costs. It is important that you understand that it is the PATIENT’S responsibility to understand their insurance benefits and financial responsibilities. We have NO input on amounts dictated by your insurance and must follow their guidelines per contract and per Explanation of Benefits. It is essential that you provide complete and accurate billing/insurance information each visit upon check-in. Please be aware that if you have an HMO product and we are not in network, services will NOT be covered. **Please read the following information thoroughly and initial each policy area.**

\_\_\_\_\_ **Co-pay:** Most insurances require co-payments. This is a fixed amount which *your insurance* dictates and is due at time of service. Co-payments can **NOT** be waived.\*

\_\_\_\_\_ **Deductible:** Most insurance plans have a deductible; a specified amount of money that the insured must pay before an insurance company will pay a claim. Deductibles are patient responsibility. Knowing your plan details is essential as a higher deductible will result in a higher balance. If your insurance has a high deductible, you may be required to make a deposit depending on the services provided and the amount already met.\*

\_\_\_\_\_ **Co-Insurance:** A percentage of allowed medical charges you will pay once your deductible is met. Your insurance will pay a percentage of their allowed amount, while you will be responsible for the remaining allowed balance.\*

*\*Please note: We are unable to “re-code” claims to enhance benefits. Additionally, we are unable to write-off/discount deductibles, co-pays, or co-insurance. This is in violation of our contracts with insurance companies. We do not recommend making healthcare decisions based solely on benefits, as care may still be necessary.*

\_\_\_\_\_ **Self-Pay:** Patients without any insurance or with a plan the practice does not accept are considered self-pay. Payment will be expected at the time of service. **OB patients must sign a self-pay OB package contract by 16 weeks gestation and complete payment in full prior to 34 weeks gestation.** Self-pay rates are already discounted and are the same for every self-pay patient.

\_\_\_\_\_ **Procedures, Surgeries, and Maternity:** Patients are responsible for all procedure charges. We ask that insurance is contacted by the patient for their own verification of coverage, benefits, and pre-certification requirements. We may require a pre-paid deposit towards any procedures, surgeries, or deliveries, based on coverage.

\_\_\_\_\_ **Lab Services:** We offer an on-site lab for our patient’s convenience. All lab billing is separate, and any inquiries should be referred to Health Lab or Quest. *If you receive a bill for lab services, please contact the appropriate lab company with any questions, not our office, as we do not have access to their information.*

\_\_\_\_\_ **Payment Arrangements:** Account balances are the sole responsibility of the guarantor. Payment of balance is due upon receipt of your statement. Balance settlement is expected in a timely fashion. If a payment plan is needed in cases of financial hardship, we may offer a short-term installment plan, up to 6 months, based on the amount owed. This payment plan must be set up as an automatic deduction each month using a credit or debit card we will keep on file. There is no discount for payment in full, as the amount owed is dictated by contract with insurance. **Any delinquent accounts will be subject to action by our collection agency – associated fees and expenses will be patient responsibility. Delinquency may also result in termination from our practice.**

\_\_\_\_\_ **Returned Checks (NSF)** A \$30.00 fee will be assessed for NSF checks.

**Printed Patient Name:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

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