Lake Barrington
WOMEN'S HEALTH CENTER, PC

THOMAS J. MEYER, M.D.
DAVID J. CRANDALL, M.D.
HEATHER R. HERBOLSHEIMER, D.O.
KELLI KILGORE, D.O.
CAROLYN JOHNSON, APRN
OBSTETRICS & GYNECOLOGY

Financial Policy

Print Patient Name:_____ **DOB**:_____

1. Patient statements are mailed monthly. Payments are due 28 days after the statement date (unless other arrangements have been made in advance).
2. If payment is not made in full **within 30 days** after insurance has settled, a non-adjustable late fee of $10 per month will be assessed to the patient's outstanding account balance.
3. Accounts that have not been fully paid, or had an acknowledgement for three (3) consecutive months will be referred to a collection agency for further processing. All fees set by the bank/collection agency/attorney will be added to the patient account balance. This service charge is non-adjustable and will be added to any outstanding balance being forwarded for collection. In addition, any non-sufficient funds (NSF) checks will incur a $30 penalty charge.
4. All no-show appointments will be charged a missed appointment fee of $80. *A no-show is considered an appointment to which a patient does not come and did not call to cancel 24 hours before the time of the appointment.* No-show appointment fees are expected to be paid. When a patient makes an appointment, it is her responsibility to attend that appointment. Every attempt is made, 1 to 2 days prior, to inform her of her obligation; however, sometimes we are not able to contact the patient directly. A reminder call is intended only as a courtesy.
5. Co-pays are due at the time of service.
6. All patients are responsible to know and monitor their own insurance benefits. Important things to pay attention to are co-payments, deductibles, wellness coverage, telephone consultations and services not covered by your insurance plan.
7. Patients will be charged a medical record duplication fee following the guidelines set by Federal and Illinois State mandates.

I understand the above stated financial policies of Lake Barrington Women's Health Center. I have been given an opportunity to have all my questions answered regarding these policies.

I also assume full responsibility of payment for all services regardless of insurance coverage and agree to pay in full after my insurance responds unless other arrangements are agreed upon in advance with the office. Should I default on my payment obligation, I agree to be responsible for and to pay all applicable attorney and collection fees incurred.

Signed:_____ Date / /

Questions Addressed: [_] Yes [ ] None Witness: _____

www.meyercrandall.com

22285 Pepper Road, Suite 111, Lake Barrington, IL 60010 Phone: 847-382-7330 Fax: 847-382-9654
284B Memorial Court, Crystal Lake, IL 60014 Phone: 815-893-0700