AUTHORIZATION / FINANCIAL AGREEMENT

I authorize the release of medical information to my primary care physician, referring physician or consulting physician needed to process insurance claims, insurance application and prescriptions.

I authorize payment of medical benefits for services rendered to the provider.

I authorize the use of this signature on all insurance submissions.

I understand that payment is required for all services at the time they are rendered unless I am in an insurance plan in which the practice participates. For those patients, I understand that my insurance will be billed for today's service. However, any copays due will be collected prior to seeing the provider. I understand that I am fully financially responsible for all charges not covered or denied by my insurance plan. Payment is expected within 30 days of the date of service. If payment is not received within 30 days of the date of service, a service charge may be applied.

I understand that payment is expected and appreciated at the time of service. Failure to pay the bill will result in additional fees for collection agency or attorney costs. **The doctors reserve the right to refuse to see a patient whose account has been sent to collections for non-payment.** We appreciate your understanding.

I understand that if my account is turned over to collections for non-payment, an additional 30% of outstanding balance will be added to my account.

I understand there will be a **$25 fee** charged for checks returned for insufficient funds.

I understand that any request by the patient for copies of medical records will incur a handling & copying fee within the Illinois statute.

I authorize (by supplying my home phone number, mobile phone number, email address and any other personal contact information) my health care provider to employ a third-party automated-outreach-program to use the name of my OB-GYN provider, the time and place of my scheduled appointment and other limited information for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam or balance due.

I consent to the receiving of an email reminder of my appointment, a text message reminder of my appointment and a message about my appointment being left on my voicemail, answering machine or with another individual, if I am unavailable at the number provided by me. This will only be notification of the provider, day, time and location of your appointment. No other information, such as what the appointment is for, will be given out.

I authorize and give my permission to receive emails from Gynecological & Obstetric Associates.

I understand that I am responsible for notifying the office 24 hours in advance to cancel an appointment. Otherwise, I will be responsible and billed for a **$25 No Show Fee**.

I acknowledge that I have been offered and reviewed this office's Notice of Privacy Practices (HIPAA).

Patient Name (please print): _____

Patient Signature: _____ Date: _____

Signature of Parent/Guardian/Legal Representative: _____ Date: _____