PARK WEST
FAMILY MEDICINE

FINANCIAL POLICY

If you are covered by an insurance plan and can provide a valid insurance card, we will bill your insurance company. Your insurance is a contract between you, your employer and your insurance carrier. It's your responsibility to contact your insurance carrier to make sure that medical provider is contracted with your plan/network. We will make every effort to obtain benefits information regarding what the client's insurance will or will not cover. This includes benefits that may have been quoted by your insurance company.

All patients are responsible for all charges for service rendered. If the patient responsibility portion of your charges, including charges applied to your deductible and/or coinsurance, are not paid in full **within sixty (60) days** following the billing statement, we will charge the credit card listed below for the unpaid balances. Payment plans are available for large balances and can be customized to fit your needs. Please contact (773) 929-7410 directly for more information. For smaller balances, $50 will be charged additional to the copay to pay off balances which will be due at every appointment.

CREDIT CARD INFORMATION

Name _____ Date of birth _____

Credit card: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Card number _____ Expiration date _____ CVV2 (3-digits on back) _____

Cardholder name _____ Relationship to patient _____

Billing address _____ Phone _____

City _____ State _____ ZIP _____

If you are not covered by one of our accepted insurance plans, you must **pay in full at the time of your service**. Many insurance plans do provide reimbursement for "out-of-network" care. Please contact your insurance company directly for instructions for submitting a claim.

CANCELLATION POLICY

For office visits canceled less than 24 hours in advance, or failure to keep an office appointment, patients will incur a $25 charge. We will charge that fee to the above credit card. If this occurs more than three times, the patient will be discharged from the practice.

You hereby acknowledge receipt of medical services, authorize us to bill the above credit card for such services, and agree to take actions required to pay the charges in full and to perform the obligations set forth in your agreement with the credit card issuer.

I have read and understand this financial and cancellation policy.

Patient/Parent signature _____ Date _____

Patient/Parent printed name _____

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