NORA MEDICAL GROUP
6969 N Lincoln Avenue
Lincolnwood, Illinois 60712
(847) 674-1200

Patient Payment Policy and Financial Agreement

It is your responsibility to provide Nora Medical Group with your updated insurance and demographic information at the time of your visit (i.e. current address, telephone, etc.)

The following is the payment policy and financial agreement of Nora Medical Group, S.C. We have put this policy in writing so that all patients clearly understand our billing and collection procedures:

In consideration for undertaking my care, I agree to the following:

I accept full financial responsibility for the services provided to me by Nora Medical Group. I understand that payment is due at the time of service unless prohibited by an existing contract between Nora Medical Group and my insurance company. I understand that if applicable, a co-payment is required on each visit and that there are no waivers for copayments or deductibles. If a copayment is not paid at the time of visit, your appointment will be rescheduled.

For services and procedures that are billed to my insurance, I understand that I become personally responsible for the charges, in the event my insurance company does not provide payment within 90 days and I have provided a credit/debit card listed below to cover these charges.

If the reason for your appointment is related to a workmen's compensation case, you understand that if workmen's compensation does not cover your visit, you are responsible for payment for services rendered by our physicians.

I understand that from time to time my physician might request tests, medications, vaccinations, procedures or preventative interventions that are medically necessary, but may not be covered by my insurance company. I hereby authorize the outstanding balance to be charged to the credit/debit card listed below.

I understand that a "physical" or "preventive health exam" is a thorough review of my general wellbeing. The doctor will review my medical history, perform a

complete physical exam and make recommendations concerning my health. This may include general recommendations regarding diet and exercise, age appropriate immunizations and cancer screening exams such as a pap test, prostate exam or breast exam and screening lab work.

I understand that ongoing chronic conditions and medication refills can be addressed as long as the condition is stable and does not require a significant change in treatment or additional tests. Should the medical conditions require changes in treatment, **my doctor may choose to have my physical rescheduled and address the current conditions presented**. My doctor many choose to address both the problems and the physical at the same session. I understand that there would be **two separate charges** in this instance.

I understand that for any procedures performed in the office, verification of insurance benefits will be done prior to my visit. I agree to pay a 50% deposit at the time of service, for any procedures not covered by my insurance and the remaining balance in 30 days after my procedure. I authorize Nora Medical Group to charge my credit/debit card below for any unpaid balance after 30 days. I understand that any monies exceeding my responsibility will be refunded to my credit/debit card below.

I understand that if my doctor has to fill out forms regarding my care for administrative purposes on my behalf, I may be charged $25 and that these forms should be returned to me within 10 business days.

I understand that Nora Medical Group requires 24 hours notice to cancel or reschedule an appointment, and that failure to provide such notice will result in a nonrefundable charge of $30.00 to my account.

I understand that extended payment plans should be discussed with Nora Medical Group. In the event that full payment is not received within three (3) months of an arranged payment plan, I authorize Nora Medical group to charge the remaining balance to the credit/debit card listed below.

I understand that if my account is turned over to collections, I will be dismissed from the practice and I will not be entitled to any medical services except in the event of an emergency as determined by the physician and only for thirty (30) days after I have been dismissed. I understand that I have the right to be provided with a list of physicians upon request to continue with my care.

I understand that in the event my credit/debit card is invalid or does not accept charges, I will be charged a $25.00 rebilling fee. I understand that because of

insufficient funds in my account, a charge of $25.00 will be added to my account for each returned check.

The following are allowable forms of payment: cash, check, money order, and credit or debit card.

We welcome the opportunity to discuss any aspect of our financial policy with you.

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Receipt of Notice of Nora Medical Payment Policies

I, _____, hereby acknowledge receipt of Nora Medical Group Payment Policies and Procedures. The Notice provides detailed information about how the practice processes your account.

I understand that the practice has reserved the right to change its policies and procedures that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

I have read and I understand the aforementioned policy. I hereby agree to each and every provision.

Patient Name: _____

Signature:_____Date: _____

If you are not the patient, please specify your relationship to the patient: _____

Name_____

Credit Card Number (Visa/MC) _____

Expiration Date_____

Security Code (located on the back of the card)_____

Signature_____Date_____

Witness_____Date_____