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.

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.

I understand that from time to time my physician must 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 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 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_________________