HAROLD A. NORD OBSTETRICS & GYNECOLOGY S.C.
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Phone: 309-454-3456 Fax 309-454-6977

FINANCIAL POLICY

It is our hope that you will understand that our office financial and billing policies are necessary to maintain vital health care services to our patients and community.

Our practice is committed to providing the best treatment possible for our patients and we charge what is *usual and customary* in this area. You are responsible for payment in full, regardless of any insurance company's arbitrary determination of usual and customary rates.

INSURANCE AND BENEFITS

Remember that insurance is a contract between you and your insurance company and it is your responsibility to understand the basic coverage of that contract. Please check with your insurance company to verify if a referral is required prior to your visit and what their preferred hospital choice is.

PAYMENTS

- Co-payments will be collected on the day of your appointment, as you check in. All insurance companies require that the physician collect all co-pays from the patient.
- *According to the American Medical Association CPT coding & guidelines, our office charges for treatment & diagnosing over the phone from our doctor, nurse practitioners & nurses.*

OFFICE PAYMENTS

We request that all office visit charges and office procedures be paid at the time of service, unless you are covered by an insurance plan that we are currently enrolled in.
WE ACCEPT CASH, CHECKS, DISCOVER CARD, VISA & MASTER CARD CREDIT CARDS.

PAYMENT PLANS

In circumstances where a claim is pending, or no insurance coverage exists, a payment plan may be initiated through our billing department. We will be pleased to cooperate with you in establishing a payment plan, prior to services provided.

CANCELLATIONS/NO SHOW

Our office is looking forward to participating in your healthcare. We ask that if you are unable to keep your scheduled appointment, please make every effort to contact our office at least 24 hours prior to the appointment date. In the event that you miss 3 or more appointments without cancelling, the provider may decide to discontinue your care with this office.

Patient Name _____ Date of Birth _____

Patient Signature _____ Date _____

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