

Northern Indiana Center for Pelvic Health & Gynecology
707 N. Michigan Street, Suite 102
South Bend, IN 46601
(574)367-3800

Financial Policy

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. We are committed to providing you with the best possible medical care. Our office participates in a variety of insurance plans, and we will bill your insurance plan as a courtesy, however **it is your responsibility to:**

- **Bring your insurance card to every visit.**
- **Remit payment for medical care not covered under your insurance** (deductibles, co-pays, non-covered services, etc.) at time of service.
- **Be prepared to pay your copay at each visit.** Payment may be made by cash, check or credit card. (MasterCard, Visa, Discover or Care Credit are accepted)
- **All patient due charges/prior balances will be collected at time of service.** If payment in full is not feasible, we will be happy to set up a payment arrangement with you until the balance is resolved.

We are available to work with you if you have special financial needs.

Out of Network Insurances

If we do not participate in your insurance program, our office is willing to file your claim; however, payment in full is expected within 30 days, either from your insurance program or you. You are ultimately responsible for balance when out of network. You are responsible for the difference between our charges for services rendered and the amount your insurance company remits on your behalf; regardless of their "usual and customary" determination.

Minor Patients

For patients 17 years and younger, a parent or legal guardian must accompany them and sign below (exception: patients 17 years and younger declared emancipated minors, proof is necessary). It is the parent or guardian's responsibility to bring the necessary insurance cards and also to make any payment due at the time of service. Proof of guardianship is required. We cannot examine patients 17 years and younger without a parent or legal guardian present. (We will accept a letter of medical release from a parent or guardian from an adult accompanying the minor patient.)

Additional Information

- Our charges are determined by what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. If we are contracted with your insurance company we will accept their allowed amount for the service and adjust off the contractual difference.
- If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company's Member Services Department (the number is on your insurance card).
- If we are forced to send your account for further collection action, your balance due will be increased by any fees we may incur to collect the balance due from you. If your check is returned to us by the bank for insufficient funds, your account will be charged a \$25.00 NSF fee plus any additional fees we may incur as a result of the NSF check.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and communication. Questions about financial arrangements should be directed to our Administrative Office. The office may be reached by dialing (574) 251-2107.

Please sign below to indicate that you have read and agree to this Financial Policy.

Patient Name (please print)

Signature of Patient/ Responsible Party

Date