Ravenswood Pediatrics – Dr. Todd Ochs
1945 West Wilson Street, Suite 6116
Chicago, IL 60640
872-208-6257

Billing Policy

The following sets forth the general billing policy of Ravenswood pediatrics. Please review this information and sign where indicated.

- I understand that it is my responsibility to provide the office of Ravenswood Pediatrics with current, accurate billing information at the time of check in and to notify GVS of any changes in this information.
- I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.
- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charge a $35 NSF fee. I further understand that to rectify my account, I will be required to pay with either cash, a money order, cashier's check, or credit card.
- I understand that I will be billed for any amount due by me (co-payments/coinsurance amounts/deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to and outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.
- I understand that the clinic will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.
- I understand that the clinic may also take a verbal request to use my listed credit card for payment on my account or they may also use the same listed credit card on my account should my account become delinquent, or to cover an NSF check.

My signature below confirms that I have read these billing policies and my financial obligations pertains to the physicians of Ravenswood Pediatrics.

_____ _____

Legal Signature Date

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Relationship to Patient