



RABY INSTITUTE FOR INTEGRATIVE MEDICINE
AT NORTHWESTERN
500 N. MICHIGAN AVENUE - SUITE 450
CHICAGO, IL 60611

FINANCIAL AGREEMENT
Effective June 21, 2011

Payment Terms

I agree to present a valid credit card when I schedule an appointment at the Raby Institute for Integrative Medicine at Northwestern (RABY INSTITUTE). I authorize my credit card to be used for payment in full at the time of service if I do not present a valid insurance card of if coverage cannot be verified with a RABY INSTITUTE participating insurance plan. I authorize my credit card to be used for payment of my balance, if my insurance applies a deductible or co-insurance.

I understand that the following services are not billable to my insurance company and agree to pay for these in full at the time of service:

- Acupuncture
Integrative Clinical Psychology

I understand that I will be provided an itemized statement for all Integrative Psychology Services that I may submit to my insurance carrier. RABY INSTITUTE does not guarantee that my insurance will cover any of the services rendered.

I understand that if I am unable to remit payment at time of service, and I have not presented a valid credit card, my appointment may be cancelled and/or rescheduled for a later date.

Insurance Coverage

I acknowledge that it is my responsibility to verify and understand my insurance coverage, office visit co-payment responsibility, deductibles, and co-insurance and maximum benefits prior to my appointment at RABY INSTITUTE.

I understand that I am responsible for all deductibles, co-insurance and other charges not covered by my insurance plan. I authorize RABY INSTITUTE to charge my credit card for any and all balances on my account over 45 days old

I understand that if past due or outstanding balances are not paid at the time of my visit, no future appointments will be scheduled and previously scheduled appointments may be cancelled.

Cancellations and Appointment Changes

I authorize RABY INSTITUTE to charge a no show fee to my credit card of \$100.00 (for existing patient) or the providers full visit fee (for new patient) if I do not present for my scheduled visit, or if I cancel/reschedule with less than 24 hours notice. If I change my exiting appointment, I understand that it is my responsibility to cancel the old appointment to avoid a charge for missed appointment.

I authorize RABY INSTITUTE to charge my credit card for any checks returned "Non Sufficient Funds" for the amount of the check, plus additional \$25.00.

Credit Card# _____ Name on Card _____ Card exp. Date _____
Card code on back

I have read and understand the Financial Agreement. I fully agree to each of the statements herein.

Print

Signature

Date