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Patient Authorization and Financial Policy

I _____ acknowledge and understand that my bill for services I have requested and received will be sent to the insurance I have provided. Any unpaid portion including deductible, co-pay, co-insurance, or rejected claim is my full financial responsibility. It is my understanding that I will pay the entire balance in full once the insurance has settled the account.

INSURANCE PAYMENT MEDICAL INFORMATION AUTHORIZATION I authorize the release of medical or other information to my insurance company and authorize payment of medical insurance benefits to be issued to: LINOCLN PARK OBGYN, S.C. at 2800 North Sheridan Road, Suite 205 N, Chicago, IL 60657. I permit a copy of this authorization to be used in place of the original. I agree to pay any unpaid portion including deductible, co-pay, co-insurance, or rejected claim is my full financial responsibility. It is my understanding that I will pay the entire balance in full once the insurance has settled the account.

Patient's Signature: _____

Date: _____