PATIENT CARE AGREEMENT

AS A PATIENT OF CHICAGO WELLNESS CENTER I AGREE TO THE FOLLOWING:

- If for any reason my insurance company does not make a complete payment to Chicago Wellness Center (CWC) within 60 days of my office visit, I understand that I will be sent a bill explaining my amount due. If I do not send a payment to CWC within the following 30 days, I hereby authorize you to debit my credit card for the total amount due.

- In the event that my insurance company denies payment or applies the visit charges to my deductible, I understand that I am responsible for the amount billed by CWC. If I do not respond to the bill and make a payment within 30 days of the bill being sent, I authorize you to debit my credit card for the total amount due.

- In the event that my case is an accident, personal injury, or workman's comp, I understand that CWC will pursue all efforts to receive payment from the responsible parties. However, once a year has passed from my discharge date and payment has not been made to CWC, I authorize you to debit my card for the amount due. I will be refunded should CWC ever receive payment in the future.

- If a check that I have written to CWC is returned, I hereby authorize you to debit my credit card for the amount of the check plus any related service fees.

- If for any reason I am unable to make my appointment and I do not notify CWC at least one hour before the appointment time, I authorize you to debit my credit card for the cost of an office visit.

We at Chicago Wellness Center strive to make your visit worthwhile, and by providing these guidelines, we can continue to offer you the best possible care.
If you have any questions or need to make special payment arrangements, please feel free to call us and discuss it. We appreciate your cooperation.

NAME: ____

CREDIT CARD NUMBER: ____

EXPIRATION DATE: _____/______

CIRCLE CARD TYPE: *AMEX* *VISA* *MASTERCARD* *DISCOVER*

SIGNATURE: ________________________________ DATE: ______________

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