



PAYMENT POLICY

As a courtesy to our patients, we offer the following billing choices. Please initial the payment plan that applies to you then sign at the bottom of the page.

Although we at Chicago Wellness Center (CWC) will contact your insurance company to verify your benefits, we recommend that you also call in order to fully understand your plan options. If you are aware of any limitations on your insurance benefits, please notify us immediately to allow us to try to maximize your coverage.

_____ **SELF PAY**

I will pay for all services as they are rendered on the date of my visit. I understand that I may contact CWC for required documentation if I choose to submit my own insurance claims.

_____ **INSURANCE SUBMITTAL**

I would like to assign my insurance benefits to CWC and have you submit my insurance claims for me. If applicable, I understand that I am responsible for obtaining any necessary preauthorization from my primary care physician. I understand that I am responsible for any balance as billed to me by CWC that results from co-payments, deductibles, or non-covered services. I will also sign over to CWC within 5 business days any insurance checks mailed to me that are owed for services received at CWC.

_____ **AUTO ACCIDENT/PERSONAL INJURY CLAIM**

I was involved in an accident and would like to assign benefits to CWC and have you submit all charges to my insurance for me. I will sign all liens necessary to protect your office. I also understand that, regardless of the settlement, I am personally responsible for the entire balance. If CWC is not paid within 30 days of the case settlement, I will personally pay the entire overdue balance.

_____ **WORKER'S COMPENSATION CLAIM**

I was involved in an injury at work. I will ensure that my employer files the appropriate paperwork as needed for CWC to receive compensation. I understand that it is in my rights as an Illinois resident to have any bills paid that are incurred as a result of a work related injury. If after 60 days of my visit to CWC my claim is not paid, I understand that I am responsible for the overdue balance.

Name (please print): _____

Signature: _____ Date: _____