1901 North Clybourn, Suite 301
Group Business Title: Balance Health + Wellness Chicago, IL 60614

Patient Care Payment Agreement

Insurance Definitions and Terms

Deductible: Your deductible is the cash amount owed in full by the patient before the insurance will agree to pay. The deductible is re-activated each year.
Co-pay: After the deductible has been satisfied, the co-pay is the patient portion of the cost of services for each individual visit. Again, if the deductible has not been met the co-pay is not activated. The patient co-pay may be a flat rate or a percentage.
In network vs. out of network: A patient may or may not have out of network benefits. Blue Cross Blue Shield is our only in-network insurance at this point in time.

For charges billed to insurance:

1. In the event my insurance company does not make payment to you within sixty (60) days of your billing, I will become personally responsible for the amount on my credit card listed below.
2. Any insurance check that may be forwarded to me for services received at Chiropractic Resources, PC, (Group Business Title: Balance Health + Wellness), within five (5) business days of receipt, for payment of my account. If I do not clear this portion of my account within five (5) business days of said payment, I hereby authorize you to collect the full amount of my account balance on the credit card listed below.
3. In those instances in which an insurance company has made partial payment for services, I authorize you to collect outstanding balances ("patient portion"/"patient responsibility," including co-pays, deductibles, non-covered services) on my credit card listed below.
4. I understand that if, as an insurance patient, I am unable to show for my appointment or I cancel less than 24 hours prior to my reserved time, I, the patient, will be charged in full, but not exceeding, the full price of my therapeutic services and will receive a statement within five (5) business days of the miss appointment.

For charges NOT billed to insurance:

1. Any appointment cancellation that I make less than 24 hours prior to the reserved time, I authorize you to collect up to, but not exceeding, the full price of the visit fee of my credit card listed below.
2. If I should make payment by check that proves to have insufficient funds, I authorize you to collect the non-payment, plus $10.00 returned check fee, on the credit card list below.

Name: ____
(Please print)

Credit Card (please circle one): **Visa** **Master Card**

Card Number: ____

Expiration Date: ____________________ Security Code: ________________

Signature: ______________________________________ Date: ____________

Witness: _______________________________________ Date: ____________

_______ I prefer to have statements mailed to me before charging my credit card so that I have the opportunity to pay by check. However, I understand that if payment is not received within 3 weeks of the statement date, the balance due will be charged to the credit card listed above, including a $10.00 late payment charge.