Williams Chiropractic Center

Dr. Eric P. Williams

1617 Ogden Ave. #6
Lisle, IL 60532
(630)969-1780
fax: (630)969-1864
office@wcclisle.com
www.williams-chiro.com
www.facebook.com/lislechiropractor

Insurance / Cash Plans

I, being a patient of Dr. Eric P. Williams, understand that payment for services is due at time of service.

PATIENTS USING INSURANCE:

If I am using insurance, I understand that the insurance company quotes benefits and it is not a guarantee of payment. Payment for service is due at the time the service is rendered unless other arrangements are made in advance. Should my insurance company not cover as they indicated, I am ultimately responsible for full payment. Also, payment for any outstanding insurance balances over 90 days, regardless of the insurance status of these claims (including any collections fees and attorney fees) is due immediately. From that point on, if my insurance company makes any future payments regarding these claims, Williams Chiropractic Center will adjust my account accordingly. Also, should my insurance company request any claim adjustments or office notes form Williams Chiropractic Center, we are happy to do our best and resubmit your claims for payment as we would like to help you get your claims paid. Please inform our office of any requests.

If Williams Chiropractic Center does not have a copy of my current insurance card, they presume I am a cash patient until they can verify my insurance information.

PATIENTS NOT USING INSURANCE:

If I am not using insurance, I understand that payment for services is due at time of service. If payment is not made and my account goes to collections, I am responsible for any collections fees and/or attorney fees incurred.

ALL PATIENTS:

I authorize Williams Chiropractic Center and its staff to release any records needed to collect payment.

I also understand that if I am unable to make my appointment and do not inform WCC with eight hours of my appointment time, a $25.00 charge will be added to my account.

Signed: _____ Date: _____
Patient of Guardian signature (if patient is under 18)

Print Name: _____