One Goal Wellness

36735 N. Illinois 83, Ste D Lake Villa IL 60046 Office: 847-265-5600 Fax: 847-245-4491

WELCOME TO OUR OFFICE

We are committed to providing you with the best care possible and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask any questions you may have regarding our fees or your responsibility in complying with our financial policy and/or procedures. We gladly accept Visa, MasterCard, Discover, American Express, check, and cash.

- **Limited Release of Medical Information:** I authorize One Goal Wellness to make inquiries and to release any pertinent information to any insurance company, adjuster, attorney, or government agency to facilitate collections/reimbursements under these assignments.
- **Insurance Patients:** I understand that my health insurance is a contract between myself, the insurance carrier and the provider. I understand that I am ultimately responsible for any fees for services rendered to me that does not get covered by my insurance company. I understand that this office accepts billing for individual or group policies, personal injury claims, authorized workers compensation, and Medicare.
- **Authorized to Process Drafts:** I agree that One Goal Wellness shall be appointed as my agent to endorse drafts on any checks for payment of my bill for medical services rendered.
- **Assignment of Cause of Action:** In the event that any insurance company or third party obligated to make payment to me or to One Goal Wellness for the charges made for services rendered, refuses to make such payment upon demand, I hereby assign, transfer, and convey One Goal Wellness any and all cause of action that might exist is my favor against any such company or person. I authorize One Goal Wellness to prosecute said action in my name or their name to collect fees due for care rendered and legal expenses, and to resolve said claims as they see fit.
- **Collection/Attorney Fees:** I agree to pay all costs of a collection agency, if necessary, to obtain payment in the event legal action should become necessary to collect an unpaid balance due for medical services rendered. I agree to pay reasonable attorney fees or other such costs as a court might deem proper.
- **Discounts and Promotions:** I agree that any discounts or promotions given to me applies if I agree to follow the full and complete treatment plan set forth by the doctor(s) of One Goal Wellness regardless if they are currently or formerly employed. In the event that I do not follow the treatment plan recommendations and I unilaterally remove myself from care, I agree and understand that any discount or promotion I have received will become null and void and I will be responsible for the complete balance in full less any payment made by me at the time of my unilateral discharge.

Patient Name (please print): _____

By signing below, you are indicating that you have read, understand, and agree to the above conditions of this office for the year 2022:

Patient Signature: _____ Date: _____

Note: This is a confidential record and will be kept in this office. Information contained here will not be released to anyone without authorization to do so.