633 Skokie Blvd Suite 270
Northbrook, IL 60062

North Shore Physical Wellness
Dr. Maxwell Barrett

Phone: 847-513-6996
Fax: 847-513-6998

Office Financial Policy

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If You Do Not Have Insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated.
2. **If You Have Insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment. If we employ legal counsel to assist in the collection of unpaid fees, you agree to pay all legal fees and related expenses that NSPW incurs to collect the amount due.

Patient's Printed Name: _____
Signature: _____ Date: _____

Practice's Requirements

This practice:
1. Is required by law to maintain the privacy of your PHI and to provide you with this privacy notice of the practice's legal duties and privacy practices with respect to your PHI.
2. Is required to abide by the terms of this privacy notice.
3. Reserves the right to change the terms of this privacy notice and to make the new privacy notice provisions effective for all of your PHI that it maintains.
4. Will not retaliate against you for making a complaint.
5. Must make a good faith effort to obtain from you an acknowledgement of receipt of this notice.
6. Will post this privacy notice on the practice's website, if the practice maintains a website.
7. Will provide this privacy notice to you by email if you so request. However you also have the right to obtain a paper copy of this privacy notice.

Effective Date: April 14, 2003

I acknowledge that I have received a copy of the practice's privacy notice that has an effective date of April 14, 2003.

Signature: _____ Date: _____