Workman Compensation/ Motor Vehicle Accident/ Personal Injury Patient Agreement

Northwest Suburban Pain Center makes every effort to work with you and your insurance to get your treatment needs authorized. However, it requires that Northwest Suburban Pain Center have the most up to date information regarding your claim.

I understand that it is my responsibility, as the patient, to keep Northwest Suburban Pain Center up to date if changes are made regarding my claim. I understand that if any of the following below change, I will contact Northwest Suburban Pain Center at 847-255-0900 BEFORE MY NEXT APPOINTMENT:

• CLAIM NUMBER	• ATTORNEY ON CASE
• CLAIM STATUS	• LAWSUIT IS FILED
• ADJUSTER ON CASE	• LAWSUIT IS SETTLED

ATTORNEY INFORMATION: PLEASE PROVIDE THIS INFORMATION IF YOU HAVE AN ATTORNEY FOR YOUR CASE.

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ATTORNEY NAME PHONE NUMBER EMAIL

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OFFICE ADDRESS

Forms
Insurance covers only your medical care. It does not cover submitting forms that may assist you in collecting disability benefits or maintaining employment. Our fee for these services reflects the resources diverted to the effort. The fee for filling out any form(s) is $50, and must be paid before the forms are filled out. Disabled Parking placards are a $25 fee and only temporary ones are provided.

Non-Covered Services
As your physician, I want to provide you with the best care possible. If there are services that I feel are necessary for the treatment of your condition and the maintenance of your good health that are not covered by your insurance. You are expected to pay for those services in full. Let me reassure you that I will only order the tests and treatments that I feel are necessary for your treatment and care. If you have any questions about whether or not a particular service is covered by your health benefits contract. It is recommended that you contact your insurance directly with any questions or concerns about non-covered services.
I understand that Northwest Suburban Pain Center makes every effort to authorize my treatment through my claim. However, in the event any treatment through my claim is denied; then I the patient, am financially responsible for my treatment.

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Patient Signature ** Date

**I have read and understand your policy and agree I am responsible for any balance.