# Advance Health and Wellness Clinic

**Dr. Chirag H. Shah - Chiropractic Physician**
**Dr. Ankur C. Shah - Chiropractic Physician**
**Diplomate in Spinal Rehabilitation**
**Certified Acupuncturist**
**1585 Barrington Rd. DOB2 Ste 601 Hoffman Estates, IL 60169**
**Phone #: 847-490-8780**
**Fax #: 847-490-8869**

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**insurance:**

**We will verify all insurance and your benefits per your agreement with your carrier. After verification, the doctor will give his recommendations, and an appropriate plan will be designed for each individual. Please let the front desk know if you have been in some type of accident or have been injured on the job. This will enable us to give you any information necessary to serve you completely and accurately.**

**Authorization & Assignment of Benefits to**

**ATMA Chiropractic Network, DBA: Advance Health & Wellness**

1. I understand that I am responsible for the cost of chiropractic, Acupuncture & any other services provided, regardless of insurance coverage.
2. I authorize payment of insurance benefits directly to ATMA Chiropractic Network, DBA: Advance Health & Wellness.
3. You are authorized to release any information you deem appropriate concerning my health condition to any insurance company, attorney, or adjuster to process any claim for reimbursement of charges that occurred at this office.
4. I authorize and assign the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges for your services.
5. I give an assignment lien against any claims against a third party whose negligence may have caused my injury, up to the bill for treatment.
6. If any insurance company obligated by contractual agreement to pay me or you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against the said company and authorize you to prosecute said action either in my name or your name as you see fit, and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance proceeds (whether it is

all or part of what is due) I owe you.

7. In general, services will be billed to the account as they are rendered. In the event of discontinuation of care, any fees for professional services already rendered are due immediately, unless a prior payment arrangement has been made.
8. Interest is charged on overdue accounts at the annual rate of 16%.
9. Fees for returned checks and credit card chargebacks are $45 per occurrence.
10. Accounts past due over 90 days are sent to collections.

**Findings**

Insurance ____ CASH_____ Deductable_____

Insurance_____ Met?_____

Policy number_____ Co-ins._____

Group number_____ Copay_____

Active_____ Visit Limited to_____

Subscriber_____ Acupuncture_____

D.O.B_____ Massage Therapy_____

Orthotics_____

**My signature below signifies my agreement to pay in full on a cash basis if I have not provided all the necessary documents and information by the time of the second visit.**

_____ _____

**Full Name printed** **Date**

**I have read and agree with the above statement.**

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**Signature.**