NEW DAY WELLNESS CENTER
FUNCTIONAL AND INTEGRATIVE MEDICINE

FINANCIAL POLICY

Patient Name: _____ **Date of Birth:** _____

Thank you for choosing New Day Wellness Center as your health care provider. We are committed to the successful treatment of your condition. Payment of your bill is considered part of your treatment and a clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities.

Necessary Information:
You must provide our office with all current and necessary patient information, including: insurance card, state issued photo identification and signatures on all patient paperwork, at the time of services for each family member treated, or payment will be due at time of service.

Product Return Policy:
Supplements and products sold at, through, or by New Day Wellness Center are non-returnable and non-refundable.

Changes:
It is your responsibility to notify our office of any patient information changes such as name, address, phone number, email, insurance information, etc.

Self-Pay Patients:
Payment is due in full for all self-pay patients.

Insurance:
New Day Wellness Center participates with Blue Cross Blue Shield PPO. As a courtesy, our office verifies coverage prior to your visit whenever possible. However, it is ultimately your responsibility to contact your insurance company to verify coverage. Please understand that you are responsible for all uncovered charges or if your insurance company deems that you are not covered.

Co-pays:
You are responsible for remitting payment at the time of service. We accept cash, checks, and credit cards.

Patient Responsibilities:

I, the patient, understand that it is the policy of this office that all fees for services be paid at the time of treatment. (Patients with insurance should be aware that quote of benefits from insurance companies is not a guarantee of payment.) If New Day Wellness Center, referred to as the "CENTER," has accepted assignment of my insurance or I have requested a payment plan, I understand and agree to the following (see page two):

600 S. County Farm Rd., Ste. 204A • Wheaton, IL 60187 • (630) 344- 9693 • www.newdaywellnesscenter.com

- I am responsible for all fees for all services for myself and my covered family members, less any timely assigned benefit payments made to the CENTER by my insurance carrier.

- I am responsible for presenting to the CENTER all current information with ALL NECESSARY PATIENT INFORMATION, SIGNATURES, AND DATES at time of treatment for each family member treated, or payment will be due at time of service.

- I am responsible for all deductible and co-insurance balances. These are payable immediately and in full upon notice from the CENTER of the amounts due.

- I am responsible for mediating all payment claims disputed by my insurance carrier.

- I am responsible for ascertaining that I, or family members are CURRENTLY COVERED by the carrier for which I am claiming coverage, and current member information is provided to the CENTER.

- I am responsible for all costs incurred by the CENTER for collecting past-due balances on accounts including, but not limited to, service fees, court costs, attorney's fees, and agree to pay minimum statutory interest from the date of notice that the account or accounts have been declared delinquent.

- That it is a felony offense in the State of Illinois to intentionally misrepresent facts pertaining to claims for payment from an insurance carrier, and further, it is a crime to solicit the CENTER to make misrepresentations to my insurance carrier.

Signed (Insured or Guardian) _____ **Date:**_____

- I authorize New Day Wellness Center and the office of Dr. Melissa Dybala to release any information needed by my insurance company, adjustor, or attorney, that will assist in the payment of a claim.

Signed (Insured or Guardian) _____ **Date:**_____