ACCESS HEALTH CARE

MEMBER GUARANTEE FORM

I, _____ herby certify that I am eligible for
(Patient or Guardian)

Health Plan coverage with _____effective as
(Insurance Company)

of _____ through _____
(Date) (Employer)

I UNDERSTAND THAT IF THE ABOVE IS NOT TRUE OR IF I AM NOT CURRENTLY ELIGIBLE UNDER THE TERMS OF MY MEDICAL AND HOSPITAL SUBSCRIBER HEAL TH INSURANCE AGREEMENT, I AM LIABLE FOR ALL CHARGES FOR THE SERVICES RENDERED. ALSO, IF THE ABOVE IS NOT TRUE, I AGREE TO PAY IN FULL FOR ALL THE SERVICES RECEIVED WITHIN 30 DAYS FROM THE DATE OF SERVICE.

I ALSO UNDERSTAND THAT I MAYBE RESPONSIBLE FOR A DEDUCTIBLE AND COP A Y WHICH IS DUE AT THE TIME OF SERVICE.

_____
Signature of Patient or Guardian

_____
Date

The following is the agreed no show fee which you have signed and is for your future reference:

We look forward to working with you and keeping you healthy. We ask that you assist us in providing the best care for all of our patients by arriving for you appointment promptly. In the event that you are unable, for any reason to keep your appointment we would appreciate you calling 48 hours in advance and rescheduling. Your health plan does allow us to charge $35.00 in the event you do not provide us 48 hours advance notification of cancellation or no show. For you convenience, in the event of an emergency our office maintains a 24 hour voicemail system.

For your payment convenience our office accepts payments in the form of cash, check, and credit cards. Please check with the receptionist to see if any other payment methods are available.

I have read this letter and understand my health benefits and responsibility as a patient at this office. I understand that my portion of the payment is due upon service.

_____ _____

Des Plaines
488 South River Rd
Des Plaines, IL 60016
(847) 809-1395

Oak Brook
17W697 Butterfield Rd., Suite B
Oak Brook Terrace, 60181
(630) 605-7424

Hoffman Estates
1000 Grand Canyon Pkwy., Suite 209
Hoffman Estates, IL 60169
(847) 310-9816

Patient or Guardian Date

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