



LIVE WHO YOU ARE

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FINANCIAL LIABILITY AGREEMENT

I acknowledge that some portions of my exam and materials may be paid for by insurance; however I understand that I am responsible for any portions that my insurance will not remit payment for. I also understand that it is my responsibility as the patient to provide I.D. Chicago and Dr. Artim with my insurance prior to the time of exam and services. If the insurance has not been submitted prior to service, I understand that I.D. Chicago is not financially liable for any cost incurred to myself as a result of presenting inaccurate, incomplete or no insurance information at the time of service. Finally, I am aware that once payment is made for services, I.D. Chicago will under no circumstances reimburse me for any insurance claims submitted after the time of service.

Patient Signature _____ **Date** _____

PATIENT RIGHT DISCLOSURE

I have read and understand my patients rights provided to me by I.D. Chicago

Patient Signature _____ **Date** _____