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www.lakeshorewellnesscenter.com

CLIENT FEES AND PAYMENT POLICIES

Full payment for all charges is required at time of service. In special circumstances, Lakeshore Wellness Center may arrange differently. We accept payment by check, cash, MasterCard or Visa. Checks or credit cards that are denied for lack of funds will incur a fee of \$35.00. A minimum billing fee of \$2.00 monthly or 15% APR, whichever is greater, will be added to any unpaid balance after 30 days. We are committed to providing economical, quality health care.

- First Office Call \$225 (60-90 minutes)**
- Return Office Call \$ 80 (30 minutes)**
- Phone Consultations \$ 75 (30 minutes)**
- Acupuncture Only First Visit \$ 160 (60 minutes)**
- Acupuncture Subsequent Visit \$80 (30 minutes)**
- Acupuncture Facial Rejuvenation: Initial Consultation \$240 (90 minutes)**
- Acupuncture Facial Rejuvenation: Subsequent Visit \$160 (60 minutes)**

Cancellations

We require 24 hours notice received during normal business hours for cancelled or rescheduled visits. This charge includes acupuncture cancellations. There is no charge for visits cancelled with 24 hours notice. Half the cost of the scheduled visit will be charged for cancellations with less than 24 hours notice. Full fee is charged if no notice is received.

Insurance does not cover this charge; it is your responsibility.

Insurance

All charges incurred at Lakeshore Wellness Center are your responsibility. In many cases, healthcare insurance will reimburse you after you submit a Superbill provided by our office. It is up to you to submit the proper paperwork for reimbursement. **Lakeshore Wellness Center does not provide billing to healthcare insurance companies.** Not all services provided at Lakeshore Wellness Center will be reimbursed by insurance. Due to plan variances, we are unable to inform you in advance what each policy covers. It is up to you to check with your individual plan to determine coverage.

Dispensary/Supplements

All dispensaries must be paid for at time of purchase. Credit on account will be given for unopened items in sellable condition returned within 30 days.

I agree to make payments according to the policies of Lakeshore Wellness Center. I understand that some or all of the services I receive may not be covered or may have coverage limitations or restrictions under my health insurance plan. It is my responsibility to know what my plan covers.

Patient Name Printed

Patient Signature

Date