

FINANCIAL AGREEMENT

NATURALLY CHIROPRACTIC

Patient's Name _____

Policy Holder's Name (Responsible Party) _____

Birthdate _____ SS# _____ Relationship to patient _____

Phone # (if different from Patient) _____ Employer _____

Address(if different from Patient) _____

Insurance Co. _____ Policy # _____ Group # _____

FEE SCHEDULE

Service

Initial exam with computer scans and Report of Findings.....	\$110.00
Chiropractic Adjustments.....	\$40.00 - \$70.00
Periodic Dynamic Evaluation.....	\$40.00
Therapeutic/Rehabilitative Services.....	\$18.00 - \$38.00
Copy charges for records.....	\$1.00 per page copied
Returned check	\$50.00 plus the check amount
No-show to appointment without previous cancellation.....	\$40.00

We are committed to providing you with the BEST chiropractic care possible and have established our Financial Policies to achieve that goal. In accepting care, you agree to the following:

- I agree to pay for all services rendered to me at the time services are provided, unless I participate in one of the available Corrective Adjustment Plans (CAP), which are designed to be the most cost effective way to keep me and my family as healthy as possible.
- I acknowledge responsibility for my account and guarantee payment of all charges against this account.
- I understand that any portion of the balance over 90 days old will be submitted to a collection agency and subject to a finance charge.
- I agree in the event of non-payment to bear cost the cost of collections and/or court costs and reasonable legal fees, should this be required.

If I have health insurance:

- I understand and agree that health and auto insurance policies are an agreement between the insurance carrier and myself.
- I certify that I (or my dependent) have insurance coverage with the Health Insurance Company mentioned above and assign directly to Dr. Nylsa A. Correa and Naturally Chiropractic all insurance benefits.
- I authorize Dr. Nylsa A. Correa and Naturally Chiropractic to verify my benefits and acknowledge that verification is not a guarantee, since final benefits will be determined upon receipt of the claim.
- I understand that I am financially responsible for all charges whether or not paid by the insurance.
- I authorize Dr. Nylsa A. Correa and Naturally Chiropractic to release all information necessary to secure the payment of benefits.

I have read, understand and agree to abide by the above policies.

Signature of Responsible Party _____ Date _____