FINANCIAL AGREEMENT – ALL PATIENTS

Dear Patient,

We have attempted to provide you with necessary information to determine the type of care you require and also the financial information you need to determine how you wish to handle your financial obligation to this office.

These policies apply only to the services actually performed, and in no way obligates the patient to continue the course of treatment recommended. If care is discontinued, the balance is due in full within 30 days of discontinuance of care.

I have elected to use the following payment plan to finance my care at the office of Dr. Sarah Colby.

_____CASH –Payment is due at the time of services.

_____ChiroHealth**USA** –Payment is due at the time of services.

_____MEDICARE – Payment is due at the time of services.
Dr. Colby will complete all necessary Medicare forms on my behalf.

_____INSURANCE POLICY COVERAGE – Although I am totally responsible for charges I may incur in this office, I will initially pay for my yearly Deductible and the percentage and/or co-pay amount agreed upon at the time of each visit unless my insurance fails to pay its share, at which time I will pay my balance in full.

NOTE: Dr. Colby will refund any overpayments made to us, within 30-60 days as long as there is no balance on the account.

PATIENT'S SIGNATURE _____

WITNESS _____DATE _____

Dr. Sarah Colby
Clock Tower Chiropractic & Massage PC
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