PAYMENT INFORMATION

Name: ______________________ _______ _______________Date:______________

ASSIGNMENT AND RELEASE

I understand that SportsDocs Family Chiropractic Group, Inc. does not provide direct billing to Insurance Companies. I understand a billing receipt can be provided to me. I understand that I am financially responsible for all charges whether or not paid by insurance. __________**(initials)**

FINANCE AND COLLECTION CHARGES FOR OVERDUE ACCOUNTS

Following reasonable effort to collect any applicable insurance benefits, I understand and agree that I will be assessed monthly finance charges of 1.5% for all unpaid balances over 30 days. I understand a **$25 fee** will be assessed for all returned checks. In addition, I hereby acknowledge that, if my account is turned over to a collection agency, I will be assessed any and all collection fees incurred by the doctor(s). __________**(initials)**

PENALTIES FOR MISSED APPOINTMENTS

I understand that a **$80 fee** will be charged for missed or cancelled appointments **without 24 hours advance notice** (business days). Exceptions for emergencies or extraordinary circumstances may be taken into consideration. __________**(initials).**

METHOD OF PAYMENT

___Self Pay (Cash, Check, and or MasterCard/Visa accepted)

___Workers Comp: Has a written report been made to your employer?_________________

___Auto Accident/Personal Injury: Attorney Name & Phone #______________________________

By signing below, I, the undersigned, agree to and understand all above policies and statements. I attest that all personal, health and insurance information I have give to the doctor and his staff is true and complete.

Print Patient Name____Date __________________

Patient Signature (or Parent/Guardian, if minor)____

If the patient is not yet 18 years old, a parent or guardian must sign.

1743 E. McNair Dr. #400, Tempe, AZ 85283 **PH # (480) 812-9000**