

Financial Agreement

Patient Name: **Amanda Hott**

This corrective plan includes all procedures recommended by the doctor during the time period of (1/29/2014 to 1/29/2014)

Any work injury or personal injury (e.g. auto accident) would suspend this plan until that condition was resolved. The plan would then continue and be extended for the unused time purchased.

\$2,300.00	Doctor Recommended Adjustments and Therapy
(\$2,000.00)	Insurance
\$300.00	Total Investment

One Time Payment (Pay in Advance Save 15%)

15 % Discount for Pay in Advance	\$45.00 (SAVINGS)
Total Payment: (Available next 5 days only)	\$255.00 (TOTAL)

Monthly Payment

Total Investment: **\$300.00** divided by **3** months: **\$100.00**

Auto Charge: **Visa / MC / Discover Credit Card #:**

Auto Bank Debit:

Financial Institution	Routing Number	Account Number
-----------------------	----------------	----------------

Financing (100% Interest Free Financing Option) Care Credit

Monthly Payment	\$25.00 for 12 months
Approximately	\$0.83 a day

By signing below, I agree to participate in a Chiropractic Corrective Program. If I've selected a payment plan, my credit card or checking account will be automatically charged on the period specified above. To cancel or change this request I must notify Accent on Health Chiropractic in writing and allow a reasonable time to accommodate my request. Should I choose to discontinue my care at any time, I will not be billed for any care not yet received and I will only be responsible for the balance of the care that I have already received. Should I choose to pay in advance for my care, my visits will be calculated on a per visit basis and I will either: a) be responsible for the outstanding balance or b) receive a refund on the care not yet received. None of the payment methods offered guarantee a cure for any condition.

1/29/2014

*Signature of Responsible Party

Date

Staff Signature