**AUTOMOBILE ACCIDENT AGREEMENT**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Phone(\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Gender: (circle one) M F Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt#:\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Service: Regular Fee:**

**Consultation No Charge Initial Exam $90.00 Periodic Dynamic Exam $71.00 Adjustment $78.00 Wellness Adjustment Plan Not Applicable**

**Automobile Accident Financial Policy**  We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time of service for auto accident adjustments unless you arrange a Chiropractic Active Life Plan in advance.

***Please check which option applies to you:***

**Regular Fees:** If you have Medical Paythat covers chiropractic care in the case of auto injury, and you choose to use it, we will file all insurance claim forms for you starting with your initial appointment. Please remember in the event of a dispute, your agreement with your insurance company is between you and them. Any unpaid balances remaining after your insurance claim has been processed will be billed to YOU and you must make a payment within 60 days following the release from care. Please note that insurance cannot be used for Chiropractic Active Life Plan.

**Personal Claim:** If you do NOT have Medical Pay or are being covered by the other party’s insurance: An Initial Exam Fee of $25.00 will be owed at the time of the first visit, and an Adjustment Fee of $39.00 per adjustment. Following the first exam, each adjustment will cost $39.00 which needs to be paid by the patient in full at the time of each appointment.Detailed receipts will be provided so insurance claim forms can be filed by the patient, separately. After the patient is released from care, the patient will be required to begin payment towards the remainder of the total balance left on the account within 60 days. This balance can be paid off in full or in monthly instilments as low as $20 per month until the entirety of the remaining balance is paid off.

**Please Initial: \_\_\_\_\_\_\_\_\_** If my insurance company fails to pay for any portion of my bill, and I do not make a payment within 60 days post release from care, please use my credit care listed below to pay off the remaining balance on my account.

**The signed credit card below is for payment of services at Ct Family Chiropractic only. The doctor agrees not to add any charges directly to my account for services that were not performed or products not purchased.** Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cardholder’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Billing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Apt#\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Credit Card: Master Card\_\_\_\_\_\_\_\_\_\_ Visa\_\_\_\_\_\_\_\_\_

Credit Card Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Expiration Date:\_\_\_\_\_\_\_\_\_\_\_\_CVV\_\_\_\_\_\_\_\_\_\_ Patients Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I, (Printed Name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and I understand the above policies. I therefore accept my chosen Automobile Accident Agreement option, and accept chiropractic care on this basis. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Signature Date