Spinal Wellness Chiropractic

2010 N. Plano Rd suite 101, Richardson, TX 75082

Financial Responsibility

Patient Name: _____ File #: _____

Cash/Check/Credit cards payment:

You are responsible for any charges /money due for services supplies by **Spinal Wellness Chiropractic** clinic as part of any/all management of your treatment and healthcare.

All payments are due before the time of services rendered.

There will be a $30 fee for any returned checks due to insufficient funds.

You will be responsible for any and all legal fees occurred while attempting to collect outstanding balances.

Assignment of Benefits: Should any member of **Spinal Wellness Chiropractic (SWC)** accept third party reimbursement for all or part of the professional fees, I hereby assign benefits and authorize the carrier or attorney to make payment directly to SWC. I understand that any remaining balance after said payment will be my responsibility as the sole party responsible for payment.

Release of Medical Records: I hereby authorize the doctor of chiropractic at the SWC to disclose to my attorney, third party carriers or agents, and my treating doctors or his/her agents with any and all medical information and related fees relative to my condition, care, and treatment as needed to determine benefits payable in connection with this injury.

I understand and agree to the previous disclaimer.

Patient's signature: _____

Date: _____