WEBB CHIROPRACTIC CENTER

Dr. Kurt K. Webb
6171 First St Suite B
Lincoln, CA 95648

ACKNOWLEDGMENT AND UNDERSTANDING

This agreement is to acknowledge that I_____ will make full payment of any balance owed to Webb Chiropractic Center for all services rendered to me by Webb Chiropractic Center for my injuries sustained in my Automobile accident which occurred on _____.

The full payment of my balance will become due and payable immediately upon my receipt of any payment from the insurance company in the settlement of my claim and or lein with them or upon dismissal from care at Webb Chiropractic Center.

Failure to provide immediate payment outlined above will result in legal action, collection agency involvement and any additional charges incurred in collecting the amount due.

Dated the _____day of_____, 20_____

_____

Patient's Signature

_____

Witness

DEDICATED TO QUALITY CARE

(916)434-0600