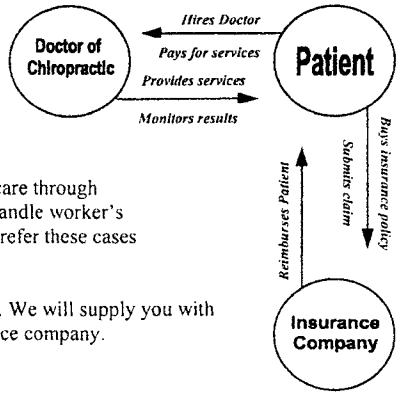
Financial Agreement

The purpose of this agreement is to clarify your financial responsibilities so we can devote our efforts to helping you get the best results in the shortest amount of time. These are the most common services we provide and when they are performed.

Procedure	Purpose	When performed	Fee
Health Screening	Meet the doctor, discuss your health problem, and review your case history.	First visit	Complimentary
Evaluation / Management [Examinations]	Ascertain the nature and severity of your health problem. Assess and evaluate your new or current health status and determine an appropriate course of action.	First visit, new condition, exacerbation, and re-examinations.	$90 - $120
X-rays	Visualize the location of spinal problems and confirm the examination findings.	If necessary, first visit, re-injuries, and at certain progress examinations.	$25 - $35 per view
Adjustment	Reduce the Vertebral Subluxation Complex and help stabilize your spinal joint problem.	As indicated by examination or evaluation.	$60 - $90
Adjunctive Procedures	Speed the healing process, help provide relief and aid in stabilizing the spine.	As indicated by examination or evaluation.	$30 - $75

Forms of Payment
Patients are responsible for full payment at the time of service.
We accept cash, personal checks, Visa and Mastercard.
Any credit arrangement must be authorized in advance.



Insurance/Contract Services/Third Party
Our office does not participate in Medicare. We serve patients who have Medicare through Preferred Chiropractic Doctor, a third party organization. Our office does not handle worker's compensation, personal injury, or automobile accident cases. We are happy to refer these cases to other offices.

All professional services are rendered and charged to the patient receiving care. We will supply you with the statements that you can submit to receive reimbursement from your insurance company. Payment for care will be due at the time of your office visit.

We are ***not*** a participating provider for any insurance companies or managed care programs. Therefore, we do not pre-certify or verify "medical" necessity with any third party programs. We will not become involved in disputes with your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information. If you have insurance coverage, our office will provide you with a form to assist you in asking certain questions to confirm your coverage limits.

Special Arrangements
We do not base your health care program on your insurance company's coverage. Many insurance companies stop covering in the middle of the care program. Our goal is to correct your problem in the shortest amount of time and the most cost-effective manner. We have never denied anyone the benefit of health care because of their inability to pay our published fees. If financial hardship is a factor you, the patient, may consult with the doctor to discuss options for how you can afford to receive care in this office.

Billing
Returned checks are subject to a $30 fee. Missed appointments without prior notice will be charged a fee of $60. Any outstanding balances are billed bi-weekly and considered past due 10 days after the invoice date or when special arrangements are not met and are subject to a 1.5% interest fee. Balances older than 30 days will incur a 1.5% interest and will be sent to a collection agency. You will be financially responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

In the event you discontinue your program of care prior to the doctor's recommendation, any special payment arrangement will be immediately discontinued and your account will be due in full immediately. The remaining balance on your account will be automatically billed to your credit card or post-dated check.

Questions
Please ask if you have any questions about this agreement or your ability to comply with its provisions. We are here to help.

Patient Agreement
I have read, understood, agreed to, and received a copy of this agreement.

Patient/Responsible Party Signature	Date	Office Representative	Date