Steinberg Consulting Services, Inc.

Patient Agreement Form for Chiropractic Services

Financials Resource

I acknowledge that chiropractic services at [your clinic name] are being provided with the following financial arrangements in place. I am currently being treated for an injury sustained on _____. I do not have or have currently depleted any personal injury protection that was available to me.

I, _____, authorize Dr. First Last to charge my credit card for any balance that exists on my account that exceeds $1000.00 at the time that services are rendered. I understand that at no time will my account be allowed to exceed the maximum of $1000.00 extended credit by the 25th of any calendar month.

I understand that Dr. First Last will charge my account $150.00, between the 1st and 5th day of each month for balances under $1000.00 until the entire balance is paid in full.

I agree to provide Dr. First Last with an open credit account number and will notify them immediately if card becomes inactive and provide another credit card to continue uninterrupted payment cycles.

In the event that I reach settlement for the injuries I sustained in the above accident, I agree to make full payment of any outstanding balance to [your clinic name].

Signed: _____ Date: _____

Print Name: _____

Witnessed: _____ Date: _____

Print Name: _____

Name on Card: _____

Credit card number: _____

Expiration date: _____

Type: MasterCard Visa American Express