SportsDocs Family Chiropractic Group, Inc. **Dr. L. Jon Porman, DC, CCSP**

PAYMENT INFORMATION

Name:_____ Date:_____

ASSIGNMENT AND RELEASE

I understand that SportsDocs Family Chiropractic Group, Inc. does not provide direct billing to Insurance Companies. I understand a billing receipt can be provided to me. I understand that I am financially responsible for all charges whether or not paid by insurance. **_____(initials)**

FINANCE AND COLLECTION CHARGES FOR OVERDUE ACCOUNTS

I understand and agree that I will be assessed monthly finance charges of 1.5% for all unpaid balances over 30 days. I understand a **$25 fee** will be assessed for all returned checks. In addition, I hereby acknowledge that, if my account is turned over to a collection agency, I will be assessed any and all collection fees incurred by the office. **_____(initials)**

PENALTIES FOR MISSED APPOINTMENTS

I understand that a **$100 fee** will be charged for missed or cancelled appointments **without 24 hours advance notice** (business days). Exceptions for emergencies or extraordinary circumstances may be taken into consideration. **_____(initials).**

METHOD OF PAYMENT

___Self Pay (Cash, Check, and or MasterCard/Visa accepted)

___ I am acknowledging that SportsDocs will keep on file my Credit Card for Missed appt's and I authorize the use of such card in the event I do not show up for my scheduled appt time.

By signing below, I, the undersigned, agree to and understand all above policies and statements. I attest that all personal, health information I have give to the doctor and his staff is true and complete.

Print Patient Name_____ Date _____

Patient Signature (or Parent/Guardian, if a minor)_____

If the patient is not yet 18 years old, a parent or guardian must sign.