



## PATIENT/DOCTOR AGREEMENT

The following policy information sheet exist in creating/ clarifying your financial agreement and explaining your insurance billing requirements, to make billing needs as smooth as possible.

### Services Available:

- |                            |                                       |
|----------------------------|---------------------------------------|
| *New Patient Consult/Exams | *X-Rays                               |
| *Report Of Findings        | *Spinal Adjustments                   |
| *Extremity Adjustments     | *Therapeutic Procedures               |
| *Nutrition Consultations   | *Orthotics-Custom Made Foot Orthotics |
| *Progress Evaluations      | *Supplements                          |

You will be charged for the appropriate services. There can be discounts given with cash accounts in custom made affordable plans. If you have chiropractic insurance that the doctor participates with, we will bill them for you. Today's visit doesn't include or imply obligation for chiropractic care. If we bill you for services rendered there will be an accompanying finance charge. There is a \$25 NSF Charge for all returned checks.

**Assignment/Direct Payment to Doctor:** For Private and Group Accident/Health Insurance.

I hereby instruct and direct the \_\_\_\_\_ Insurance Company to pay by check and mail directly to:

**DISCOVERY WELLNESS CENTER, 1631 15th Ave. West, Ste 114 Seattle, WA 98119**

If my current policy prohibits payment to doctor, then I hereby also, instruct and direct you to make the check out to me and mail it to the above address, for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

### **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY:**

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional services charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney involved in this case.

### **MISSED/CHANGING CHIROPRACTIC APPOINTMENTS**

We will set aside time for your chiropractic appointment for you to receive treatment with the Doctor. If for any reason you may be unable to keep your scheduled appointment, you must give a 2 hours notice for chiropractic appointments or be charged to you the personal service charge of \$35.00.

By signing below I indicate that I have read the above policies and agree to the applicable conditions.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Today's Date