Financial Agreement

I authorize my insurance company to pay Schwartz Chiropractic and Wellness, all insurance benefits otherwise payable to me for services rendered. I authorize the use of the signature on all insurance submissions. I authorize Schwartz Chiropractic and Wellness to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

For my convenience, I authorize the release of any medical information necessary to process this bill to my insurance company and request payment of benefits to Schwartz Chiropractic and Wellness, Inc. All past due accounts are subject to a finance charge of 1.5% per month or max allowed by law. The understanded responsible party promises to pay for services in accordance with the above terms. In the event it becomes necessary for Schwartz Chiropractic and Wellness, Inc. to incur collection costs or institute suit to collect any amount under this agreement, the undersigned promises to be responsible for charges incurred, to pay all additional costs, charges, collection fees and expenses, including reasonable attorneys' fees and costs, if incurred for the collection or otherwise and submits to jurisdiction and venue in Dodge County, WI. A fee of $25 will be applied to my account for each returned check. All rates are Time of Service Rates and must be paid at the time of service.

CANCELLATION POLICY: A 24-hour notice is required for all cancelled appointments. For any missed and or no show/no call appointments, a $25 service fee will be applied to my account.

PRINTED NAME: _____ **DATE:** _____

SIGNATURE: _____