Cappiello Chiropractic
Patient Payment Agreement

This Chiropractic office expects payments for services performed. To help you in your desire to come under chiropractic care, we offer several payment plans. Please indicate how you intend to pay for these services.

___ Cash, check credit card (Visa or Master Card)
___ Payment Plan **

In the event of non payment, I understand and agree that any credit granted shall be paid promptly in accordance with the terms and agreements, that Cappiello Chiropractic may add 1.5% per month to any balance owed. In the event of default I authorize this office to charge my credit card, indicated below, for the total amount due to date.

____Visa ____ Master Card

Cardholder Name_____

Credit Card # _____

Expiration Date _____ **CVC**_____

Cardholder Signature _____

Date _____

I understand the information listed above and that this office may report my account to a collection agency to receive payment.

Patient's Signature_____ **Date**
_____

Witness_____ **Date**
_____

**** Various payment plans are available depending on need and ability to pay. A minimum dollar amount and payment schedule is required and must be approved by the office staff to receive this plan.**

This office accepts/participates with an extremely limited number of insurance carries. Please inquire with your insurance carrier and with office staff to understand you insurance benefits as they relate to our office.