All first visit charges are payable in full when the services are rendered.
The fee paid for x-rays is for analysis only. The film itself is the property of this office.

I understand and agree that health and accident insurance policies are an arrangement between the Insurance company and me. Furthermore, I understand Kent-East Chiropractic will prepare any Necessary reports and forms to assist me in making collections from the insurance company and That any amount authorized to be paid directly to Kent-East Chiropractic will be credited to my Account upon receipt. However, I clearly understand and agree that I am personally responsible For payment.

Patient's Signature: Date:
Guardian's Signature authorizing care for a minor:
In case of emergency, please notify nearest relative not living with you.
Relationship Address & Phone #

I plan to make payments for services rendered as follows:
Cash Insurance Name of Insurance
Insurance Address
Policy # Group #
Insurer's name: Birthdate:

FOR OFFICE USE ONLY:

Chiropractic Coverage:
Preferred Provider:
Deductible Amount Amount Met
Co-pay X-ray Coverage
Office visits per year

Non-Preferred Provider:
Deductible amount Amount Met
Co-pay X-ray Coverage
Office visits per year

Special instructions or limitations:

Verified by: Completed by:

Date ______________________________