

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 _____

Kent-East Chiropractic
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