Patient Payment Agreement

I, _____, (print first and last name) understand that the services rendered to me by Wholistic Chiropractic Center, (which includes the services of Dr. Richard C. Gerardo, Dr. Don Brosseau, Brian McGee, Janeen Lapple & Jeri Evans Nutritional, Inc.) are to be paid on the same day that the treatment is provided, unless otherwise arranged prior to my appointment.

A $5.00 per visit service charge will applied on accounts that require *medical billing*.

Any ***unpaid balances*** over 60 days are subject to a 1% (one percent) interest charge per month.

Once I have an appointment, it is my responsibility to be on time. A 24 hour notice from my appointment time is mandatory if I wish to re-schedule or cancel. **I realize that I am responsible for a $75.00 missed appointment charge if less than 24 hours notice is given.**

All emergency weekend visits other than in the office are $100.00 at the time of service. Any non-emergency scheduled night or weekend appointment will have an additional $20.00 fee.

All supplements are to be paid for at the time of purchase. All sales are FINAL. No refunds unless approved by management. A 25% Restocking Fee PER supplement on all UNOPENED items. Credit is issued if there was a discrepancy with the supplement.

I also understand that if Wholistic Chiropractic Center bills my health insurance, that **I am responsible to pay** any deductible and co-payment/co-insurance fees/percentage that the **insurance does not cover**. I understand that I am ultimately responsible to pay for all services provided in this office, if my insurance does not pay.

I understand that there are cash payment discounts available.

Patient Signature: Date:

Office Witness: Date:

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