

For Our New Members Without Insurance Coverage

We believe a clear understanding of our *Financial Policy* will allow us both to better concentrate on the big issue, ***regaining and maintaining your health.***

Therefore, it is agreed between us, that payment will be made in full at the time services are rendered or made in full at the end of each week. It is also understood that the office policy of Scituate Harbor Chiropractic (SHC) mandates that your balance may not exceed \$135.00.

I understand this financial policy fully, and hereby agree that if I should terminate care for any reason, my outstanding balance becomes due and payable immediately. I also understand that my account must be kept current in order for SHC services to be continued.

I have read and understand this policy.

Member Name (please print)

Member Signature

Date

Witness Name (please print)

Witness Signature

To expedite said payment, unless other arrangements are made, I agree to authorize SHC to use the following credit card (*we will notify you before taking this action*):

Credit Card Type: _____ Card #: _____

Authorized Signature: _____ Expiration Date: _____