Patient Payment Arrangements

Patient Name: ______________________________ Date: ______________

Treating Specialist:

____ **Walter Tonyes, DC**
Scotchtown Chiropractic
633 Route 211 East, Middletown, NY 10941

____ **Bryan Weslowski, MA PT**
Scotchtown Physical Therapy
633 Route 211 East, Middletown, NY 10941

Primary Insurance Company: ____

*** **Please Be Advised: Your insurance company may deny payment for your care.** This also applies to insurances that require authorization or prior approval for your treatment. There is NO GUARANTEE OF PAYMENT. The insurance company will make the final determination on your case when the bill is received and reviewed by them. *****

Payment Arrangements For Services Rendered

Co-payments	Daily	_______		
Deductible	Daily	_______	Weekly	_________
Cash (no insurance)	Daily	_______		
Pre-Paid Cash Plan	Monthly	_______		

** Upon completion of the recommended treatment plan, any unpaid balance will be billed to you on monthly invoices. You agree to make regular/consecutive payments. (For any remaining balance up to $100, a minimum of $25 per month will be due. For balances greater than $100 a minimum of $50 per month will be due to pay off your bill.) Any account that is sent to collections will be subject to that agencies fees.

Financial Arrangements & Hardship Documentation

Comments:

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Patient Signature: ______________________________

Consulting Employee: ___________________________