Burlington Family Chiropractic PATIENT PAYMENT APPLICATION

Today's Date
It is our office policy that payment is due at the time of service. However, we understand that occasionally
patients may need to make a temporary payment agreement while receiving necessary chiropractic care. Your
health is our first concern and we are willing to extend the following payment arrangements upon approval:
I (alegae wint warms).
I (please print name):
agree to pay for rendered services at the time of service and an additional \$ per
beginning on (date) until
the above account(s) is clear
my circumstances are re-evaluated in 6 months (date)
Additional Notes
*Responsible Party Signature:
If you would like us to apply payment to your credit card per the terms of your agreement please supply your
credit card information below:
Credit Card Number:
Credit Card Parimoer.
Expiration Date: Security Code:
Name on Credit Card:
*Responsible Party Signature:
Staff Initials: Date:
Stari initials Bate
*This agreement does not include any fees in which a 3 rd party is responsible for payment
Office Personnel will fill out bottom portion of this form
Patient Payment Application Approval
Dationt Names
Patient Name:
Will pay \$ per in addition to all current fees at time of service beginning
Will pay \$ per in addition to all current fees at time of service beginning on the above date requested by the patient. Our Office Manager will contact the patient if payment on account
is not paid on specified date.
Office Manager: Date:
Note in Computer Remarks Original in File Copy to Office Mngr Copy to Patient
Doctor's Initials