PERSONAL INJURY FINANCIAL POLICY

This is an agreement between Skye Chiropractic and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" means the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we," "us," and "our" refer to Skye Chiropractic.

Charges to Account: Upon reaching an agreement with your insurance company or attorney, charges may be made to your account without payment at time of service during your personal injury claim. We shall have the right to cancel this privilege at any time if circumstances between this office and your attorney or insurance company change. When appointments are not made and kept according to your treatment plan, you may be released from our care due to non-compliance. Treatment may no longer be charged to your account. The bill from your personal injury treatment may or may not be transferred to you.

Authorization: I authorize Skye Chiropractic, and their respective agents and contractors to contact me regarding my balance at the current or any future phone number that I provide for my cellular phone and other wireless device using automated telephone dialing equipment or artificial or pre-recorded voice or text messages.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in effect. You may receive a copy of this agreement upon request.

Insurance and payments: While you are under care for your personal injury you authorize us to send your records and bills to the appropriate companies. (i.e. auto insurance company or attorney) You authorize your insurance company(s) or attorney to pay benefits directly to Skye Chiropractic. If benefits are paid directly to you the patient, payment for your full bill will be expected promptly after your settlement is reached. Any unpaid balance over 30 days post settlement will be transferred to our collections agency. **If we refer your account to a collection agency, you agree to pay your balance in full in addition of up to 66.67% in collection fees.** The insurance company will make the final determination of your eligibility and amount of the settlement. If you disagree with any verification or payment on your behalf, it will be your responsibility to pay your account balance in full. Any discrepancies will be handled between you and your insurance company.

Returned Checks: There will be a $**30.00** fee assessed for all returned checks.

I have read and understand the financial policy and agree to all terms and conditions stated herein. I agree to make payments on my account on each date of service. I also understand that if no payment is made on my account after 60 days, my account will be subject to be sent to a collection agency/attorney and agree to pay all costs/court costs incurred if such an event should happen.

Patient's Name:_____

Responsible Party (if not the patient):_____

Signature:_____ Date:_____