

*Dudko Chiropractic, LLC
9010 Lorton Station Blvd.
Lorton, VA 22079*

FINANCIAL AGREEMENT

Thank you for allowing our office to serve you. Please read, sign and date this form to acknowledge your understanding of your financial relationship with our office.

I, the undersigned, hereby agree to pay the above-named doctor all fees due him/her for services rendered. Payment is to be made at the time of service unless alternative arrangements have been made in advance.

I, the undersigned, Authorize Dr. Suzanne Dudko, to provide a referral for X-rays, study models, photographs or any other diagnostic aids deemed appropriate by him or her to make a thorough diagnosis of my condition. I also authorize Dr. Suzanne Dudko to perform any and all forms of treatment, and therapy that may be indicated in connection with treatment, and further authorize and consent to the employment of such assistance as he or she deems fit.

Insurance

Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. Some have annual caps or multiple levels of coverage. I understand that payment of my bill is my legal obligation as the patient. All filings of insurance papers and confirmation of insurance payments to be made by my insurance carrier are my responsibility, as is determining providers covered by my current insurance. Any assistance in this matter granted by the above doctor and/or staff is given strictly as a courtesy and implies no responsibility on their part for eligibility, filing, following-through, or confirmation. Notification of change of insurance carrier or level of coverage (e.g. PPO) is my responsibility, as is any change of address.

Delinquent Accounts

IN THE EVENT THAT THIS ACCOUNT SHOULD BECOME DELINQUENT AND IS THEREFORE PLACED IN THE HANDS OF AN ATTORNEY FOR COLLECTION, I AGREE TO PAY ATTORNEY FEES OF 33 AND 1/3% OF THE UNPAID BALANCE OWING, PLUS ALL COURT COSTS, AND INTEREST. INTEREST IS CHARGED AT A RATE OF 1.5% PER MONTH (18% APR), 30 DAYS AFTER THE MONIES HAVE BECOME DUE OR EXPENSES HAVE BEEN INCURRED. I FURTHER AGREE TO PAY RETURNED CHECK CHARGES OF \$50.00 PER RETURNED CHECK AND \$75 PER APPOINTMENT CANCELLED WITHOUT 24 HOURS NOTICE. ANY PROFESSIONAL/COURTESY, DISCOUNT GIVEN UPON EXECUTION OF THE PAYMENT TERMS OUTLINED ABOVE MAY BE REVERSED AT THE DISCRETION OF THE PRACTICE IF THE ACCOUNT GOES INTO DEFAULT

This agreement is reaffirmed each time services are received by me or any person on my account, including, but not limited to, any child, stepchild, spouse or parents within my family, who receives services from the above-named provider or any other provider within the practice.

Signature

Date

Print Name