FINANCIAL POLICY

Stanton Chiropractic, Inc., Dr. Brian J. Stanton, D.C.
2975 Fairview Road CM, CA 92626
(714) 662-2142

Dr. Brigide L. Daily, D.C.
2975 Fairview Road CM, CA 92626
(714) 662-0670

- All first visit charges are payable when services rendered.
- Method of payment you plan to use to take care of today's charges?

  ☐ Cash ☐ Check ☐ Debit Card ☐ Visa/MasterCard ☐ AmEx

  - I understand that health/accident insurance policies are an arrangement between the insurance carrier and myself. **INITIAL** _____
  - I clearly understand and agree that all my services rendered me are charged directly to me and that I am personally responsible for payment. **INITIAL** _____
  - I understand that if the insurance company does not pay promptly (within 30 days), then I will be charged for services rendered. I authorize charges to the credit card on file and/or listed below. **INITIAL** _____
  - I understand that if the insurance company issues check to you, the patient, and the payment is not brought into our office promptly (within 30 days), then I will be charged for services rendered. I authorize charges to the credit card on file and/or listed below. **INITIAL** _____
  - I also understand that if I suspend or terminate my care at this office; any outstanding charges for professional services rendered me will be immediately due and payable. I authorize charges to the credit card on file and/or listed below. **INITIAL** _____
- PLEASE NOTE: AFTER ENTERING CREDIT CARD DATA INTO SECURE COMPUTER (ENCRYPTED), YOUR CREDIT CARD INFORMATION BELOW THE LINE WILL BE SHREDDED.

Name on Credit Card: _____

Signature: _____ Date: _____

MASSAGE THERAPY POLICY

1. If you are unable to keep your scheduled appointment, you must notify our office at least twenty-four (24) hours in advance. **INITIAL** _____
2. If you are a no show, or do not cancel 24 hours in advance, there will be a $35 charge per half hour appointment. **INITIAL** _____
3. If you are running late, we will wait ten10 minutes for you. After 10 minutes you will forfeit your appointment, and be charged for your session. **INITIAL** _____

I understand and agree to the above Massage Therapy Policy, and I authorize charges to the credit card on file and/or listed below. **INITIAL** _____

Signature: _____ Date: _____

Credit Card Number: _____

Expiration Date: _____

3 Digit Code: _____

Billing Zip Code: _____