Dr. James E. Hollingsworth
• Chiropractic Physician
• Diplomate American Academy of Pain Management
• Clinical Member American Psychotherapy and
Medical Hypnosis Association

Financial Agreement
Please fill out completely

Financial Agreement

Name of person responsible for payment_____

Method of payment: Cash_____ Insurance_____Visa/Mastercard_____ Other_____

INSURANCE COMPANY: Please give your insurance card to the receptionist to copy for your file.

Primary Insurance _____ Address _____

Group #_____ Membership # _____

Secondary Insurance _____ Address _____

Group # _____ Membership # _____

Payment is expected at time of visit, unless other arrangements are made.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any neccessary reports and forms to assist me in making collections from the insurance carrier and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable and that interest is charged at the rate of 1.5% percent per month (18% per annum) on those amounts 60 days and over. I further authorize and allow Dr. James E. Hollingsworth, associates, and his staff to perform necessary tests and to render appropriate chiropractic care, clinical hypnosis, and counseling.

Patient's signature_____ Date_____

Parent or Guardian _____ Date_____

Information taken by_____ Date_____