BYER CLINIC OF CHIROPRACTIC

"Tender Care to Improve Spinal Function"

DR. CARL E. BYER

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Credit Card on File Agreement

Name of Patient: _____ Date: _____

Byer Clinic of Chiropractic, Ltd. makes every effort to collect the appropriate payment from our contracted insurance plans for all billable services. Some services may not be covered or not paid in full by your insurance carrier due to various reasons.

I clearly understand that my insurance carrier may consider my charges and/or service(s) as medically unnecessary, or apply benefits to my co-insurance or annual deductible. If the balance on my account is not covered in full, I understand that I am responsible for the entire, outstanding balance, regardless of reason for nonpayment by my insurance carrier. I will receive one statement requesting payment, if payment is not received, my credit card listed below will be charged as approved by me.

My signature below authorizes Byer Clinic of Chiropractic, Ltd. to charge the outstanding balance to my credit card listed below.

_____ _____

Signature of Patient/Responsible Party Date

_____

Name on Credit Card

_____ _____ _____

Credit Card Number Code Expiration Date

_____

Authorized Signature