DELTA WELLNESS GROUP
Chiropractic • Nutrition • Massage

Dr. Glen Alis, D.C. , C.N.S.
Dr. Supna Alis, D.C. , C.N.S.

FINANCIAL AGREEMENT

I understand that health and accident policies are an arrangement between my insurrance company and myself. As a courtesy, Delta Wellness Group will bill any eligible policy that i may have. I agree that I am completely responsible for all financial charges inccured on my account. I understand and agree that I am considered a "cash basis account" that all services must be paid for at the time of service. I understand that there is a **$35.00 charge for missed massage appointments** (cancellation must be received 24 hours before scheduled appointment) and that a **$25.00 fee may be debited (electronically) from my checking account on all checks returned from my bank as "Non Sufficient Funds"**. Finally, I understand that if for any reason my account becomes delinquent and a legal suit is filed I agree to pay all collection, court and attorney's fees and all unpaid services or fees rendered by this office.

Signature of Patient, Parent, Guardian or Personal Representative _____ Date _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claim(s) and aslo certify that all insurance information to this clinic is correct and complete. Further, I understand I am to notify this office immediately if this information changes in any way, is terminated or results in COBRA benefits.

Signature of Patient, Parent, Guardian or Personal Representative _____ Date _____

AUTHORIZATION FOR PATIENT CONTACT

I authorize the doctor and the doctor's office to contact me at my work and/or at my home and/or at my cell contact numbers. Further, I understand I am to notify this office if my contact information changes. I would prefer to be called at: ☐ Home ☐ Work ☐ Cell

Signature of Patient, Parent, Guardian or Personal Representative _____ Date _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge the doctor and/or the doctor's staff has provided me with a paper copy of Notice of Privacy Practices, or an electronic copy of the Notice of Privacy Practices, or has offered the opportunity to read the Notice of Privacy Practices. I understand I may request a copy of the Notice at any time.

Signature of Patient, Parent, Guardian or Personal Representative _____ Date _____

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I hearby authorize _____ to pay by check the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay in a current manner any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Signature of Patient, Parent, Guardian or Personal Representative _____ Date _____

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