FINANCIAL POLICY AND AGREEMENT

("Agreement" – Rev.05-05-05)

I, the undersigned, in consideration of the office's agree to the following terms:

Incorporation of Assignment Terms and Definitions. In this agreement "Office" and "Clinic" shall refer to somatic chiropractic P.A. dba Pavilion Chiropractic, Mitchell Shuchman D.C. or Robin Palmisano Shuchman D.C.. I have reviewed the office's Assignment form titled in short as "Assignment" or "Assignment / Lien." The terms and definitions contained in the assignment are incorporated herein by reference.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total charges from the Office. Except where provided otherwise by contract, I agree to pay the full amount of my charges to the Office upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. Unless otherwise mutually agreed to in writing on a form provided by the Office, I agree that any partial payments received by the Office towards my Charges shall not constitute acceptance of my installment payment plan, shall not constitute a waiver of the Office's right to receive payment-in-full upon demand, and shall not constitute an accord and satisfaction of my Charges, regardless of any such terms of restrictions indicated on, or included with, any payments.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment"). Without limiting the foregoing, I understand that a payer may Deny Payment, stating that the Charges is "not a covered benefit" under its policy or exceeds some other limitation. I understand that a payer may claim, based on internal criteria that a particular Charge is or was not medically necessary or was not sufficiently documented, and should therefore be denied or downcoded. I further understand that a Payer may require certain Charges to be pre-certified or pre-authorized. I understand that there may be other situations where a payer may Deny Payment based on a particular contractual term applicable to me or to the Office (Term of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all terms of Non-Coverage prior to incurring any Charges at the office. I further agree that should the Office assist me in the verification process, I assume the risk that the payer and/or the Office may fail to accurately understand or communicate to me the terms of Non-Coverage. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office liable in any foregoing instances.

Collection of Higher of Allowed Amounts When Two or More Payers Are involved. Unless otherwise agreed to in writing, I authorize and direct the Office to submit my Charges, as well as a copy of an assignment, to any and all Payers including, without limit, my health benefit plan. I understand that some or all of these Payers may utilize fee schedules to which the Office has agreed or as imposed by law (allowed fees"). I further understand that the fees allowed or utilized by one Payer may exceed the fees allowed by another Payer. In the event that the fees allowed or utilized by one Payer exceed the fees allowed by another Payer, I hereby authorize the direct the Office insofar as permitted by law to collect its charges up to, but not in excess of, the higher of the two amounts. In the event that a particular Payer does not utilize any fee schedule at all, I direct the Office to collect up to its full Charges.

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the Office to endorse or sign my name on any and all checks listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents regardless of whether these other Charges are related to my condition.

Miscellaneous Provisions. Except as provided in this paragraph, this Agreement shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Agreement. I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall , nevertheless, remain in full force and effect. This Agreement shall be governed under the laws of the state where the Office is located and is performable in the country where the Office is located. In any action based upon this Agreement, may treatment, or my Charges, I hereby consent to personal jurisdiction and venue of any court is said county and waive all objections based on improper jurisdiction, venue, or forum non-convenience as such term is defined by law. I further wave any statute of limitations which may apply in any action based upon this Agreement, may treatment, or may Charges.

I have read, understood, and agree to the terms of Agreement

Patient Name (print): _____

Patient Signature: _____ Date: ____ / ____ / ____

Name of Custodial Parent of Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature: _____ Date: ____ / ____ / ____