FINANCIAL AGREEMENT

Out of Network

$ _____ Deductible

$_____ Patient Agreement

In Network

$ _____ Deductible

$ _____ Patient Agreement

Total = _____ Paid on = 1st 15th Amount Per Month = _____ Number of Months = _____

Card Holder Name_____ Phone _____ Zip Code_____

❑ Visa ❑ MC Card # _____ Exp:_____/_____ CV Code_____

PATIENT INSURANCE APART OF ANY FEDERALLY FUNDED PROGRAM OR AID **YES** **NO**

Patient acknowledgment: _____

Date: _____

By signing below I fully understand the doctor's recommendations and understand the financial obligation of co-pay and deductible (*if any*), in addition charges for services will be billed directly to my insurance company. Some patients might receive the physical check at their residence and are responsible for turning over to MedWell LLC for services rendered.
NOTE: PATIENT RESPONSIBLE FOR REPORTING CHANGES IMMEDIATELY OF INSURANCE AND CAN BE HELD FINANCIALLY LIABLE.

Patient's acknowledgment: _____

Date: _____

Special Arrangements:

Patient's acknowledgment: _____

Date: _____

By signing here I am stating that my financial responsibility for the co-insurance (or my co-pay) and the deductible would be a financial hardship for me at this time. I understand that this office is relieving me of, or assisting me with this financial burden so that I can receive the agreed upon course of care, on the condition that I complete my treatment plan.

Financial Interest of Entities

In compliance with the requirements of law R4-7-902.1, you are hereby advised that John Eby has a direct financial interest in MedWell LLC and Pain Associates of Gilbert. Further, patient understands that this is a medical office run by a Medical Director, MD/DO, and that the treatment protocol of this center includes multiple services including therapeutic injections, chiropractic, physiotherapy, x-ray & ultra sound. All services we recommend are available elsewhere on a competitive basis.

We ask that you acknowledge your having read and understood the disclosures contained in this Notice by signing and dating this form in the spaces provided below. We will keep the signed original in your patient file.

Patient's acknowledgment: _____

Date: _____