

HOW MUCH WILL IT COST?



Name

(Last)

(First)

(Middle)

Date

Phone #

Address

TREATMENT SCHEDULE

Visits per week x # of weeks

Relief x = (Visits) x = (Visits)**Correction** x = (Visits) x = (Visits) x = (Visits)**Total # of Weeks:**

Visits

x Cost / Visit**Total Cost****Estimated Insurance Payment****Patient Contribution**
(Includes co-insurance, co-pays, and deductibles)

TWO PAYMENT OPTIONS:

☐ 1. Installment**Total Cost \$**

Number of Installments

Cost per Month \$

☐ 2. Pay in Full (Calculated with a % discount)**Lump sum payment of \$**
(Visa, Mastercard, and American Express accepted)

Please be aware that our fees are based on the outlined treatment schedule. Should your condition require further care, you will be responsible for the increase in cost. By signing below you agree to the terms set forth above.

Patient Signature/ Date
Michael LeRoux, DC

Ocean State Chiropractic & Sports Rehabilitation