OSC #001

HOW MUCH WILL IT COST?

SPORTS REHABILITATION & CHIROPRACTIC

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

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