Dr. Dave W. Pool, B.S., D.C.

2403 Santa Fe Drive, Ste. 7

Pueblo, CO 81006

719-543-7894

Financial Agreement

I, ______________________________ certify that I and/or my responsible party have health insurance coverage with ______________________________ insurance company or will be **SELF PAY.** I do assign directly to **David W. Pool DC** all insurance benefits, if any, to be paid to **David W. Pool DC**. I understand that I am financially responsible for any and all charges whether or not paid by my insurance company; including co-pays, co-insurance or deductible amounts, and examinations and therapies deemed necessary and appropriate. I understand that if my account becomes delinquent beyond 90 days, that I may be turned over to a collection agency and a charge of 100% of the owed amount will be added to the account. I also understand that if said bill is not paid and is turned over for collection actions, I will be responsible for any and all collection costs, attorney fees, court costs and any other costs incurred by Dr. David W Pool, PC during the collection actions. (Unpaid accounts referred to outside agencies for collection bear interest at the current legal rate.)

If this agreement is signed by the patient's spouse, parent or legal guardian, the patient's spouse, parent or legal guardian shall be jointly and individually liable for payment, including all collection fees (attorneys' fees, court costs, and collection expenses), in addition to any other amounts due.

I hereby authorize David W. Pool DC to release any and all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I authorize Mesa Chiropractic to initiate a complaint to the Insurance Commissioner on my behalf, if necessary.

I have read and understand this statement and agree to all terms stated above.

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Signature (Patient, Parent, Spouse, Legal Guardian) Date

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Printed Name Relation to Patient