

**LAMBOY  
CHIROPRACTIC**  
245 Conklin Street  
Farmingdale NY 11735  
516-249-4488  
516-249-4058FAX

Financial Consideration Form

I understand and agree that this consideration is only for patients with special financial concerns.

I understand the fees being considered are not the usual and customary fees as established by the above office, and are not the prevailing fees in the area, and/or established by fee facts. I will not seek reimbursement by any third party or insurance company, such as health insurance, auto, Medicaid, medicare, or workers' compensation. I am fully responsible for my health care and the bill. In qualifying for this consideration, I understand and agree that Lamboy Chiropractic, will not be required to do any billing to insurance and/ or other parties.

Finally, if the circumstances, which qualify me for this consideration changes (insurance coverage via a personal injury, or I have access to any health insurance coverage) or social or economic circumstances allow me to pay the established fees in full, I will immediately notify Lamboy Chiropractic within 10 days of the change status and utilize my new benefits and/ or pay fees as established below. I understand that Lamboy Family Chiropractic will then charge their usual customary rates.

The reduced rates are:  
ADJUSTMENT = \$45 EXAMINATION=\$45 X-RAYS \$45

I fully agree that when I sign below, I will be required to follow the doctors recommendations concerning my care. If I am unable to follow the outlined schedule program for corrective care, I will be dismissed from this contract and future visits will be at the usual office fees. I will also be responsible for any unpaid balance of services rendered to date. I will attend an office workshop and encourage others to attend as well. In consideration the cooperation given me by the office, I will assist in telling the Chiropractic story to others and encourage them to seek Chiropractic care as well.

Arrangements are as follows for: Patient: \_\_\_\_\_

I agree to pay Lamboy Family Chiropractic \$\_\_\_\_\_ per week/ month for \_\_\_\_\_ weeks/months, to be paid on the \_\_\_\_\_ day of each consecutive week/month (payment to be made in office)

I understand these terms and agree to abide by them

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witnessed \_\_\_\_\_ Date \_\_\_\_\_