SHOAR
CHIROPRACTIC

Community Outreach Program/Hardship Agreement

Date/Fecha:_____

To whom it may concern:

By my signature below I am requesting that my doctor at **Shoar Chiropractic, Inc.** reduce normal and customary fees charged so as to allow me to receive Medical and chiropractic care.

My financial circumstances are such that if I were to pay the customary fees charged I would be forced (due to economic reasons) to not receive treatment.

I recognize that my agreement made to assist me is purely confidential and that my fee arrangement would be different than that which is standard in the office.

If my insurance company policy demands full payment of the deductible or co-payments, I agree that it is my responsibility to notify my insurance carrier that due to economic hardship, I am only making a partial payment.

Por mi firma abajo estoy pidiendo que mi doctor en **Shoar Chiropractic, Inc.** reduzca el costo de sus honorarios y así permitir que yo reciba tratamiento Medico o quiropráctico.

Mis circunstancias financieras son tales que si yo pagara los honorarios acostumbrados seria forzado(a) (por razones económicas) a no recibir tratamiento.

Yo reconozco que mi acuerdo hecho para asistirme es puramente confidencial y que mi arreglo del honorario será diferente que el que es estándar en la oficina.

Si mi póliza de seguro requiere pago total de mi deducible o co-pago, yo estoy de acuerdo que es mi responsabilidad de notificar a mi compañía de seguro que por dificultad financiera, yo estoy solo haciendo el pago parcial.

_____ _____

Patient's name/Nombre del paciente **Patient's signature**/Firma del paciente

_____ _____

Witness name/ Nombre del testigo **Witness signature**/Firma del testigo