**Initial**

For: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name)

**Intensive** **Financial** **Plan** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Name  
Practice Address  
Practice Phone

*Recommendations* *are* *based* *on* *findings* *from* *your* *initial* *consultation* *and* *evaluation* *including* *posture,* *ranges* *of* *motion,* *chiropractic* *tests* *and* *x-rays.* *Also* *taken* *into* *account* *are* *how* *long* *subluxations* *have* *been* *present* *and* *what* *phase* *of* *degeneration* *they* *are* *in,* *as* *well* *as* *your* *age* *and* *overall* *health.* *All* *recommendations* *are* *an* *estimation* *based* *on* *education* *and* *clinical* *experience* *and* *take* *into* *account* *patient* *participation* *and* *follow-through* *in* *their* *own* *care.*

**Your** **recommended** **initial** **care** **time:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your** **Time:**

Daily for \_\_\_\_\_\_\_\_weeks \_\_\_\_\_\_\_adjustments 3x for \_\_\_\_\_\_\_\_weeks \_\_\_\_\_\_\_adjustments  
2x for \_\_\_\_\_\_\_\_weeks \_\_\_\_\_\_\_adjustments  
1x for \_\_\_\_\_\_\_\_weeks \_\_\_\_\_\_\_adjustments

**Your** **Intensity:** **(in** **numbers)** \_\_\_\_\_\_ Adjustments  
\_\_\_\_\_\_ SWS Workshops (@ minimum)

\_\_\_\_\_\_ Re-exams & Progress Reports \_\_\_\_\_\_ Re-X-rays  
\_\_\_\_\_\_ Exercises

**Finances** **(anticipated):**

$ (including cost of exams)

**Estimated Contribution:**

[ ] Insurance - $\_\_\_\_\_\_\_\_\_\_

**Features** **and** **Benefits** **of** **Initial** **Intensive** **Care:**

1. Each **Chiropractic** **Adjustment** builds on the previous. Each adjustment builds towards a healthier, better aligned and more ideally functioning spinal column.

2. **Spinal** **Care** **Workshops** help you get well quicker and stay well longer and should be part of your care plan as long as you want to continue to enhance your health.

3. **Home** **cervical** **traction,** **stretches,** **posture** **exercises** **and** **core** **strengthening** are added as care progresses. The more engagement there is at home, the better your results will be.

4. **Progress** **evaluations** are done approximately every \_\_\_\_\_\_\_\_ visits to measure ongoing results, and care may be adjusted based on your progress.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Month** | **Duration** | **Description** |  | **Fees** **for** **Services** | **Insurance/** **Admin.** **Savings\*** | **Est.** **Monthly** **Swipe** |
| **1** | \_ \_ / \_ \_ to \_ \_ / \_ \_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ Adjustments \_\_\_\_\_\_\_\_\_\_ Re-exam/report | **2** **SWS** | **$** | **$** | **$** |
| **2** | \_ \_ / \_ \_ to \_ \_ / \_ \_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ Adjustments \_\_\_\_\_\_\_\_\_\_ Re-exam/report | **1** **SWS** | **$** | **$** | **$** |
| **3** | \_ \_ / \_ \_ to \_ \_ / \_ \_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ Adjustments \_\_\_\_\_\_\_\_\_\_ Re-exam/report | **1** **SWS** | **$** | **$** | **$** |
| **4** | \_ \_ / \_ \_ to \_ \_ / \_ \_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ Adjustments \_\_\_\_\_\_\_\_\_\_ Re-exam/report | **1** **SWS** | **$** | **$** | **$** |
| **5** | \_ \_ / \_ \_ to \_ \_ / \_ \_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ Adjustments \_\_\_\_\_\_\_\_\_\_ Re-exam/report | **1** **SWS** | **$** | **$** | **$** |
| **6** | \_ \_ / \_ \_ to \_ \_ / \_ \_ | \_\_\_\_\_\_\_\_\_\_\_\_ Adjustments ( 1 ) Re-exam/report ( 1 ) Re-Xray | **1** **SWS** | **$** | **$** | **$** |
| **7** | \_ \_ / \_ \_ to \_ \_ / \_ \_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ Adjustments \_\_\_\_\_\_\_\_\_\_ Re-exam/report | **1** **SWS** | **$** | **$** | **$** |
| **8** | \_ \_ / \_ \_ to \_ \_ / \_ \_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ Adjustments \_\_\_\_\_\_\_\_\_\_ Re-exam/report | **1** **SWS** | **$** | **$** | **$** |
| **9** | \_ \_ / \_ \_ to \_ \_ / \_ \_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ Adjustments \_\_\_\_\_\_\_\_\_\_ Re-exam/report | **1** **SWS** | **$** | **$** | **$** |
| **10** | \_ \_ / \_ \_ to \_ \_ / \_ \_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ Adjustments \_\_\_\_\_\_\_\_\_\_ Re-exam/report | **1** **SWS** | **$** | **$** | **$** |
| **11** | \_ \_ / \_ \_ to \_ \_ / \_ \_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ Adjustments \_\_\_\_\_\_\_\_\_\_ Re-exam/report | **1** **SWS** | **$** | **$** | **$** |
| **12** | \_ \_ / \_ \_ to \_ \_ / \_ \_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ Adjustments \_\_\_\_\_\_\_\_\_\_ Re-exam/report | **1** **SWS** | **$** | **$** | **$** |
| **Estimated** **Total** (swipes will be made monthly on the date of patients’Report of Findings) | | | | **$** | **$** | **$** |

*\*Administrative* *savings* *are* *point* *of* *service* *savings* *only* *applied* *if* *there* *is* *no* *third* *party* *contribution.*

**Administrative Savings Guidelines:**

* Payment must be linked to a credit card or checking account, securely kept on file
* Payment is to be made for the next month’s projected services on the due date
* Payment will be automatically debited on the \_\_\_\_ of the month (an in-office account audit will be run to ensure accuracy)
* If more or less services are used, the monthly swipe will be adjusted (monthly)
* Patient engagement in monthly educational series is required
* If care is discontinued the patient will be refunded any valid credit ***minus administrative savings.***

**EZ-Pay Signature-On-File Authorization**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize **(name of practice)** to initiate payments from my credit or bank account with the financial institution identified by me on this form for payment of services and/or products provided by **(name of practice)**.

\_\_\_\_\_\_\_\_ (initial) I understand that this authorization will remain in effect until I cancel it in writing and I agree to notify **(name of practice)** in writing of any changes in my account information or termination of this authorization at least 5 days prior to any further charges to my credit card or bank account.  I certify that I am an authorized user of this credit card/bank account and will not dispute these transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form. Notice to cancel can be given by either mailing to: **(address),** emailed to: **(email)** or faxing to: **(fax).**

|  |
| --- |
| **CREDIT CARD** *(last 4 digits)* \_\_\_ \_\_\_ \_\_\_ \_\_\_ (Circle One) VI, MC, AM, DI  Expiration Date: \_\_\_\_\_/\_\_\_\_\_ CID Code: \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_  Card Holder’s Printed Name:  Signature: Date: |
| **ACH BANK ACCOUNT** *(last 4 digits)* \_\_\_ \_\_\_ \_\_\_ \_\_\_  Bank Name:  Bank Account Holder's Name:  Signature: Date: |

\_\_\_\_ (Initial if Personal Injury) In the event my insurance company sends payment to me and I do not bring the check in to **(name of practice)** within one week of receipt, the amount of the check will be charged to the payment method identified on this form.