

SPINECARE DELAWARE, LLC

FINANCIAL AGREEMENT

I _____ (PRINT NAME) AUTHORIZE SPINE CARE DELAWARE TO AUTOMATICALLY CHARGE MY CREDIT/DEBIT CARD FOR THE REMAINING BALANCE FOR OF MY _____ (DATE) OF PROCEDURE.

PLEASE CHECK BELOW:

_____ \$100 - \$250 - 50% DUE AT TIME OF PROCEDURE 50% ON _____ (DATE OF WITHDRAWAL)

_____ \$250 - \$1,000 – 50% DUE AT TIME OF PROCEDURE THEN 2 PAYMENT OF \$25% ON _____ (DATE OF WITHDRAWAL) STARTING ON _____

_____ \$1,001 PLUS – 50% ON DAY OF PROCEDURE AND SIX EQUAL PAYMENTS STARTING ON _____ (DATE OF WITHDRAWAL)

VISA/MC/DISCOVER _____

EXPIRATION DATE _____

CVV CODE _____

SCD ACCT # _____

Patient's Signature _____

Today's Date _____