

I understand that I remain personally responsible for the total amount due Villines Chiropractic, P.C. for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This agreement shall not be modified or revoked without the mutual written consent of Villines Chiropractic, P.C. and myself. I hereby revoke any previous signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interest of Villines Chiropractic, P.C. and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all portions and provisions of this Agreement shall, remain in full force and effect.

Patient Name (please print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Attestation for Child/Minor Dependent**

Name of Custodial Parent or Legal Guardian (please print): \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_