

Our fees for your initial visit:

Examination	\$70.00
(Chiropractic x-ray, if needed)	(\$50.00)
TOTAL	\$ 120.00

In the event your WSIB claim is rejected the fees are your responsibility. We require a credit card number on file in order to protect your account. You credit card will only be charged in the event that you have been denied treatment.

I fully understand the above fees and give my consent. I also give my consent to have the doctor take any x-rays he/she deems appropriate to better understand my problem and monitor my progress.

Credit Card Number: _____

Name on Card: _____

SIGNATURE: _____ DATE: _____
(Signature of Parent/Guardian required if patient under age 18)

Thank You!