DEFY
THERAPY & WELLNESS

Full Name *

First Name Last Name

Date *

Month Day Year

Deductible:

In
Out

Amount

Full deductible amount

Amount

Full deductible amount

Has or Has Not been met:

Has
Has not been met

CoPay (if applicable):

Full deductible amount

CoInsurance (if applicable):

Full deductible amount

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Payments will be accepted as follows for your treatment

I, acknowledge the above information is correct and I hereby agree to follow the above protocol *

I agree

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