CHART #: ____

COMPREHENSIVE Wellness Center

Your Path To Maturing Gracefully

PLEASE INITIAL BELOW THE PAYMENT METHOD THAT YOU PREFER:

_____ I will pay cash for all visits and treatments at this medical office.

.

_____ Please bill my health insurance for services provided at this medical office. I will pay all deductibles, each copayment and coinsurance due at the time of services provided.

_____ _____

Client Name Date

_____ _____

Client Signature MRN

SAINT ADEOGBA MD
9712 WEST MARKHAM LITTLE ROCK, AR 72205
(501) 954-8800