Chiropractic Fee Schedule

(Effective January 2001)

Service	Fee
Consultation	NO CHARGE
Chiropractic Examination	$28-$175
Chiropractic Adjustments	$40-$55
Chiropractic X-ray studies (per view)	$45
Instrumentation (Tempo scope/DTG)	$20
Emergency Visits (Non-office/off-hours)	$100
Clinical Nutritional Analysis	$50-$100

(All fees are standard and primarily based on our professional association guidelines)

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your chiropractic care at our office, and you may choose the plan which best fit your needs. Please read carefully and choose the plan that you prefer. This information will enable us to better serve you and help to avoid misunderstandings in the future. If special arrangements are necessary, please consult with the doctor. Our main concern is your health and well being, and we will do our best to help you.

Plan #1-INSURANCE: You have insurance that covers Chiropractic care; we will bill your insurance directly. You will be responsible for your deductible, co-pay and any other out of pocket expense. In the event the insurance check should come to you, you are expected to bring the check to us. Some insurance companies have limits on Chiropractic care; at that point, inquire about our affordable health and wellness plans. If insurance benefits are not verifiable on the initial visit, you will be expected to pay 20% of the total charges.

Plan #2- CASH: Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance.

Plan 3- MONTHLY/ YEARLY CASH AGREEMENTS: For those patients who are interested in conditioned based care, health care, and wellness care, we offer several different cash agreements for extended care. This plan applies to all cases, except work injury or auto injury claims.

Plan #4- AUTO INJURY: You need to supply us with the accident report, your car insurance, health insurance, and liable parties insurance, and attorney if applicable. We will bill your insurance directly after verification of coverage. In the event the check should come to you, you are expected to bring the check to us.

I QUALIFY AND UNDERSTAND PLAN#_____ AND ITS REQUIREMENTS.

SIGNATURE____ DATE________________

PATIENT OR AUTHORIZED PERSON'S SIGNATURE

A. I authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or the party who accepts assignment below.

B. I authorize payment of any medical benefits from____________________________________ to be paid directly to this Chiropractic clinic for any service rendered to me.

Date____________________________ Signature____

AUTHORIZATION ANDASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance
Company, attorney, or adjuster, in order to process any claim for reimbursement of charges incurred.

2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payments to me or you based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated by contractual agreement to make payment to me or you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe you.

4. In the event that my insurance company (or companies) does not cover the charge for treatment or deems such treatment "medically unnecessary", then I understand and agree that I will be responsible for, and agree to pay for, the cost of the treatment provided.

Date ____________________________ Signature__________________________________

INSURANCE DEDUCTIBLE AGREEMENT

I agree to pay ant deductible balance owing on my account. I understand that my deductible is my responsibility.

I agree to pay $__________ per visit, per week, or per month, to pay off my balance.

Failure to abide by this agreement will result in legal action for collection of full amount of bill.

I have read the above provisions and wish to participate in this program. I hereby agree to abide by the provisions of this program as specified above.

Date________________________ Signature_______________________________________