



FINANCIAL AGREEMENT

The purpose of this agreement is to clarify the financial aspects of your care. It is our desire to assist our patients whenever possible. The following insurance assignment program allows you, our patient, to receive the care you need without undue financial strain

Procedure	Purpose	When Performed	Fee
Initial Consultation	Patient conference with the chiropractor and detailed review of health history.	First Visit	\$62
Initial Report	Discuss the nature of you health problems and determine the appropriate course of action.	Second Visit	Included
Progressive Exam	Determine progress of patient case.	Doctor will determine	\$45
Digital Imaging	Visualize the spine and perform spinal analysis, and confirm findings.	First visit, re-injuries, and at certain progress exams, as necessary.	\$50-\$150
Adjustments	Reduce the Vertebral Subluxation Complex and stabilize your spinal or joint problems	As indicated by office visit or examination.	\$47
Intersegmental Traction	Increase flexibility of the spine.	As indicated by office visit or examination.	\$20
Massage Therapy	Therapeutic, deep tissue for scar tissue reduction	As indicated by office visit or examination.	\$60/hr

1. Waiting for insurance payment is a courtesy provided by this office. We reserve that right to withdraw this courtesy at any time. We will bill your insurance company and accept assignment of benefits during your corrective care period. Direct assignment will be discontinued when you have finished corrective care and supportive health care program is recommended. We will notify you of the change.
2. All deductible and co-pay amounts must be paid by you in advance of the first billing. Also, you must stay current with your percentage of responsibility. This must be paid at least weekly. Prepayments may also be made. Account balance must not exceed 200.00.
3. The insurance carriers are billed weekly. It is your responsibility to supply this office with necessary forms to complete billing if needed.
4. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within three days of receipt.
5. If you discontinue your care for any reason other than discharge by the doctor, you will be responsible for any unpaid balance regardless of any claims submitted to your insurance company, at the time you discontinue care.
6. This office does not promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, it will be the patient’s responsibility to pay all the charges and pursue reimbursement from the insurance company on his/her own. The insurance company has 30 days from billing date to make this decision. Patient payment is expected on any fees over 30 days old.

PATIENT AGREEMENT

I have read, understand, and agree to the terms of this financial agreement.

Patient/Responsible Party Signature

Date