Chiropractic Center
Financial Policy

Most Common Services	**Billed Fee**
New Patient Examination	$125.00
Established Patient Re-evaluation	$35.00
Spinal Manipulation (1 area)	$45.00
Spinal Manipulation (whole spine)	$55.00
Extra-Spinal Manipulation (hand, shoulder, foot, etc)	$40.00
Maintenance Visit	$40.00
Electrical Stimulation Therapy	$25.00
Heat Therapy	$15.00
Therapeutic Exercise	$40.00
Massage (per 15 minutes)	$30.00
Cervical (Neck) X-ray	$61.00
Thoracic (Mid-Back) X-ray	$64.00
Lumbar (Low-Back) X-ray	$65.00
*Supports/Vitamins/Supplies	Priced as marked

*Not covered by insurance. All other services above may be covered by your insurance plan, depending on your policy.

_____**Patients with Insurance**: We will bill your insurance for services rendered in the office. We will check on your benefits prior to receiving care, however insurance companies will never allow that a quote of coverage is a guarantee of benefits. **We will collect 100% of services not covered by your insurance carrier. If you have a copay, coinsurance or unmet deductible, you will be responsible for payment at time of service.** Please note that some patients' policies are written to where they may have to pay a deductible for certain services, and/or a copay for certain services. Insurance is a contract between the patient and their carrier, so it is important that you take responsibility for understanding your benefits. If your policy prohibits collection of deductible and/or coinsurance prior to claim processing, we will require a credit/debit card to be kept on file. Payment for services not covered due to unmet deductible, coinsurance amount or policy exclusions will be automatically processed after receipt of Explanation of Benefits (EOB) from your insurance carrier. **Patient Initials ____ Staff Initials _____**

_____ **Medicare/Medicare Advantage Patients**: **Medicare Part B only covers manipulation of the spine**. All other services are not covered and will be your responsibility. **You will be required to meet your annual Part B deductible, which is currently $_____ and pay 20% of the allowed fee on the spinal manipulation, which is currently $_____, in additional to 100% of all non-covered services.** Medicare Part B patients with a Supplemental policy will generally have their Part B deductible and the 20% covered by the supplement. However supplemental policies generally do not pay for services that medicare does not allow. Medicare patients will be required to sign an Advance Beneficiary Notice prior to starting care, any time there is a significant change in diagnosis, and/or at the beginning of each year. Medicare Advantage plans generally follow the same guidelines as Medicare Part B, except you may have a copay instead of a deductible/20% plan. **Patient Initials _____ Staff Initials_____**

CHIROPRACTIC FINANCIAL POLICY, CONT.

_____ **Medicaid Patients:** If you have Medicaid, most of your services, with the exception of supports/vitamins and supplies, will be covered 100% under your Medicaid plan. You will be required each MONTH to show proof of continued Medicaid Coverage. **Patient Initials _____ Staff Initials _____**

_____ **Personal Injury/Workman's Compensation**: Most Personal Injury and Workman's Compensation claims are covered 100%. However it is your responsibility to provide our office with the documentation necessary to prove a valid claim, as well as the name(s) of any claims adjuster/attorney, etc handling the case, claim numbers and mailing address to send bills. Failure to provide the documentation needed will result in immediate conversion of your case to cash, and all payment will be due on receipt. **Patient Initials _____ Staff Initials _____**

_____ **Patients without Insurance**. You will be required to pay for your services at the time they are rendered. You may be entitled to a network or contractual discount under the following circumstances: You are a member of ChiroHealthUSA, or any other Discount Medical Plan Organization in which we participate. Patients who are uninsured or underinsured (limited chiropractic benefits), may join CHUSA in our office, and will be entitled to network discounts similar to our insurance patients. Membership is $39.00/year and covers you and your dependents. Ask our staff for more information. **Patient Initials _____ Staff Initials _____**

_____**Financial Hardship.** If payment at time of service is going to produce a financial hardship, we do offer, with an auto-pay option, a short term payout of your bill. Please discuss this option with our staff if you feel it is necessary to complete the care you need. We also have available discounts for patients who meet state and/or federal poverty guidelines or other special circumstances. Verification will be required to qualify for a financial hardship discount. **Patient Initials _____ Staff Initials _____**

____ I have read and understand the financial policy of Chiropractic Center. I also understand that if I have insurance, or a valid auto or workman's compensation claim, my carrier may pay for some to most of the charges listed above, but no benefits are guaranteed. I understand that I am ultimately financially responsible for all services not paid by insurance or other third party. Should there be a balance due at the end of my treatment plan, I will receive an invoice for the amount and pay it promptly, or contact the office to make payment arrangements.

Printed Name of Patient/Responsible Party _____

Signature of Patient/Responsible Party _____

Date Signed _____ Witness Signature _____