Health Goals Chiropractic Center

Financial Policy

Your optimum health is our greatest concern. Therefore, it is important to us that we help you understand our office policy.

Prepayment is expected at the time service is rendered, unless arrangements have been made with our Office Manager. Patients may be eligible to use their insurance to assist with payment for services. Please refer any questions you may have regarding services or fees to the Office Manager. In the event that the fees for care would present an excessive and undue financial burden, please inform our Office Manager.

Please mark the payment option (at the right) which you would prefer and sign below to indicate that you have read and understand this financial policy.

By signing you agree to pay if your insurance plan does not cover supplies or other services listed below.

_____ _____

Patient Signature Date

Fee Schedule

Initial Examination & Consultation	$150.00
Chiropractic Adjustment Visit	$60.00
Senior Citizen Office Visit / Medicare	$50.00
Re-examination / Update (required if more than 6 months since last treatment or a new area of complaint)	$75.00
Therapeutic Exercise Prescript /Inst. (30 min)	$20.00
Modalities/Therapies Electrical Stimulation, Ice/Heat Ultrasound / Galvanic	$20.00
Extremity Adjustment	$20.00
Massage (20 – 90 minutes)	$30.00 and up
Required for Auto / Workers Comp Injury:	
Comprehensive Exam – New Patient	$170.00
Comprehensive Exam – Established Patient	$150.00
Comprehensive Re-examination	$100.00
Modalities / Therapies	$20.00
Therapeutic Massage (per 20 min.)	$20.00
OTHER:	
Orthopedic Supports	As priced
After Hours Office Visit	$75.00
Sunday / Holiday Office Visit	$75.00
Missed Appointment (without a call 24 hours prior to visit)	$25.00
Private Personal Training – 10 sessions	$400.00 and up

For those patients who have chosen one of the personal payment options, the fee for modalities/therapies will be complimentary when performed in conjunction with a chiropractic adjustment

Prices are effective 2/1/2017.

Payment Options

For your convenience, we offer a number of payment options to pay for the quality health care you receive in this office. Our staff is available to help with your insurance questions.

Personal Payment

A fully itemized receipt, containing all of the information required by most insurance carriers, will be provided upon payment.

☐ **1. Cash or Personal Check**
There is a $25 bank fee for returned checks.

☐ **2. MasterCard, Visa or Discover**

Insurance

☐ **1. Participating Provider**
We are participating providers with:
- Blue Cross / Blue Shield
- Aetna/Triad
- AmeriHealth/Personal Choice
- Qualcare/Oscar

You will be responsible for ALL **REFERRALS**, DEDUCTIBLES AND CO-PAY. **Please call your insurance company to verify benefits and to find out if you require a referral for Chiropractic services. You will be financially responsible for any services performed without a referral.**

☐ **2. Group or Private Health Insurance**
Benefits may be assigned to the doctor's office during a 90-day period of intensive care – once deductible and co-payment provisions have been verified and met. Co-payment is due at time of service.

☐ **3. Automobile Accident, Personal Injury**
If your treatment in this office is related to injuries sustained in an auto accident, benefits may be assigned to the doctor's office. Deductible and co-payment may be processed through your private insurance carrier if you provide us the necessary information.

☐ **4. Worker's Compensation**
If your treatment in this office is related to injuries sustained in an accident which occurred in the course of your employment, benefits may be assigned to the doctor's office – once a signed treatment authorization from your employer has been obtained.

☐ **5. Medicare**
We are not participating Medicare providers; therefore, patients with Medicare coverage must pay for services rendered at each visit. Our office automatically submits your claims to Medicare at the end of each month.

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Assignment

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services.

A photocopy of this agreement shall be considered as effective and valid as the original.

_____ _____

Patient Signature *Date*

Release of Information

I give my consent to this center for the use and disclosure of private health information to my insurance company, for the purposes of treatment, payment and health care operations; and hereby release this center of any consequence thereof.

I also understand and consent that my treatment may require consultations between healthcare providers for the purposes of coordination or management of my healthcare.

_____ _____

Patient Signature *Date*

Financial Responsibility

Participating and filing an insurance claim is a courtesy we extend to our patients. Your insurance plan is a contract between you and your carrier. I understand that if the doctor has not received payment from my insurance carrier within 60 days I will assist in getting my claim paid by contacting my insurance Co. I also understand that if the doctor has not received payment from my insurance carrier within 90 days that I am responsible for payment at that time.

_____ _____

Patient Signature *Date*