(208)344-4469

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 that you prefer. This information will enable us to better serve you and help to avoid misunderstandings in the future. Our main concern is your health and wellbeing. We will do our best to help you.

Professional Fee Statement:

Service	Fee
Consultation and Orthopedic/Neurological Exam/EMG	$35 - $190
Routine X-Ray Series (Cervical and Lumbar)	$160
X-Ray per Area (two x-rays)	$80
Basic Office Visit (Adjustment)	$40 - $110
Medicare Eligible Basic Office Visit	$35 - $110
Rehabilitation Procedures	$20 - $45 each
Massage	$55 - $87.50 per hour
House Calls, After Hours or Emergency	$50 - $100

Radiographs or x-rays will be recommended to evaluate architectural asymmetries, spinal subluxations, phase of hypertrophic degenerative osteoarthrosis and to rule-out contraindications to treatment such as pathologies.

IMPORTANT: All patients, with or without insurance, are responsible for full payment of the first visit, unless other arrangements have been made in advance.

Today's payment will be made by (please circle one): **cash** **check** **credit card**

☐ **Please check this box if you require or would like information on our financial needs program.**

Insurance: Please let the front desk know if you have insurance or if have been involved in some type of accident or injury. This will enable them to give you the complete forms for information necessary to serve you completely and accurately.

Agreement: My signature below signifies my agreement to pay in full on a cash basis if I have no insurance. If my provider is not a provider of services for my insurance company or if I have not provided the clinic with all necessary documents and information by the time of my second visit, I agree to pay in full on a cash basis.

I have read and agree to the above fee statement.

(Patient's Signature) (Date)

Authorization: In addition, if applicable, this authorizes my provider of medical services, including but not limited to: physicians, hospitals, therapists, chiropractors to disclose and furnish all types of medical information pertaining to my condition and to their care and treatment of me, including charges for the purpose of this authorization. I authorize the medical personnel to attain, release and provide copies of the requested information for the financial settlement, referral of, treatment, processing claims, evaluation of, settling or litigation of my case/condition. This authorization shall remain valid unless I choose to revoke it earlier in writing.

My signature below specifically allows the release of medical records (if signing as parent/guardian, please indicate) for purposes of account collection/patient referral.

(Patient's Signature) (Print Name) (Date)

(Date of Birth) (Social Sec No)

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