Financial Disclosure Form

I understand that the Doctor’s financial policy states “Fees are due and payable at the time of services”.

I understand the fees as stated below:

The Initial Visit Fee of $85 includes:

* Consultation
* Exam
* Report of Findings with treatment recommendations

OTHER SERVICES AND FEES:

Office Visit / Spinal Manipulation $35\*

Lab Work: FULL PRICE

Rehab Therapy $15 - $25\*

Physical Therapeutics $15 - $25\*

Nutritional Consult/Evaluation $80 - $120

*(Therapies may be one of the following, but is not limited to this listing: hot pack, cold pack, vibratory massage, neuromuscular therapy, or myofascial release)*

Take-Home items must be paid for at the time of purchase and includes:

*Nutritional supplements, hot/cold packs, pillows and exercise equipment are individually priced*.

***FINANCIAL RESPONSIBILITY***

PAYMENT & INSURANCE

I understand and agree that the health and accident insurance policies are an arrangement between the insurance carrier and me. This office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to me and that I am personally responsible for payment. I also understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*Prices subject to change and Doctor’s discretion*