<u>Office Fee Schedule and Financial Policy</u>

Service	Fee
Consultation	Vary By Needs
Initial Exam and Report of Findings	$125.00-$200.00
Children 5 and under Exam and Report of Findings	$50.00
Re-evaluation and Report of Findings	$50.00-$100.00
X-ray – Cervical	$50.00
X-ray – Thoracic	$50.00
X-ray- Lumbar	$50.00
Chiropractic Adjustment	*$45.00
* Adjustments paid the same day: discount ($10.00)	$35.00
Physiotherapy	$20.00
Emergency Office Visit	$65.00

Wellness Plans Are Available After Initial Intensive Care

<u>Financial Policy</u>

1. Health Insurance: If you have insurance that contributes to your chiropractic care, we will submit your insurance for you as a service. Remember, your agreement with your insurance company is between you and them. Insurance is a quote of benefits not a guarantee of payment.

2. If you acquire insurance for a special situation such as an auto accident or a worker's compensation injury and choose to utilize that coverage, you will be charged our regular office fees until such claim is settled. We will help you get reimbursed quickly with these claims.

We are committed to providing you with the <u>best</u> Chiropractic care possible in a <u>caring</u> environment and have established our financial policies to achieve that goal. You will be expected to pay for your Chiropractic Care at the time of service unless you have arranged a Wellness Plan in advance. The Wellness Plans are designed to be the most cost effective way to keep you and your family as healthy as possible. Details of these plans will be discussed with you during your first Re-evaluation.

I ACCEPT FULL RESPONSIBILTY FOR ALL TREATMENT PERFORMED BY DR. MARY ANN BOUGH. I understand that should my account become past due, I will be responsible for all fees, interest charges, late charges, and all costs of collection including, but not limited to, attorney's fees and court costs. My signature on this form authorizes the release of any information relating to claims filed on my behalf and also authorized payment sent directly to Dr. Mary Ann Bough. I have read and understand the above policies. By signing, I authorize treatment on (Patient name) ______________________ and accept full financial responsibility.

Date: ____________________ Signature: ____________________________________