**Professional Fee Schedule**

**Consultation** **Chiropractic X Ray Studies**

Free $80.00 to $350.00

**Chiropractic Examinations** **Adjunctive Therapies**

$65.00 to $230.00 $30.00 to $50.00

**Chiropractic Office Visit Therapeutic Exercises**

$50 to $220.00 $45.00 to $90.00

(All fees are primarily based on our professional association's guidelines)

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 needs; please read carefully and choose the plan that you prefer. This information will enable us to better serve you and help to avoid misunderstandings in the future. If special arrangements are necessary, please consult the doctor. Our main concern is your health and well-being; we will do our best to help you.

**PLAN 1 Insurance:** If you have insurance that covers Chiropractic care, we will bill your insurance company directly. Please allow the front desk receptionist to photo copy your insurance card to confirm your coverage. If you do not have an insurance card, we will need the insurance companies’ name, the primary person on the policy, their social security number and their birth date. Until we have the necessary information to verify chiropractic coverage, you will be required to make payment for your care. If you have insurance, but it has not been verified on your initial visit 20% of charges are due at that time. In the event the check should come to you, you are expected to bring the check to us. Please be sure to include the E.O.B (explanation of benefits).

**PLAN 2 Cash:** Fees are to be paid at the time of services rendered unless special arrangements have been made in advance. Please consult with the doctor if special arrangements are needed. Pre-paid plans are available for your convenience.

Plan 3 Injury: You need to supply us with an accident report, car insurance, liable parties’ insurance and attorney if applicable. Until necessary information is gathered and verified for chiropractic care, you will be required pay for your care. We will bill your insurance company directly. In the event a payment should be mailed to you, you are expected to bring the payment to us.

Please note: all patients with or without insurance, are responsible for full payment of their first visit. If arrangements need to be made, please do so in advance of your appointment.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_

## Overlake Chiropractic

## 15615 Bel-Red Rd. Ste A Bellevue, WA 98008 (P) 425-883-0133 (F) 425-702-6366

Jan. 2015