

# A PERFECT CURVE CHIROPRACTIC—PROFESSIONAL FEE SCHEDULE

## Jenna Land, D.C.

Consultation.....	\$50.00
Chiropractic Examinations.....	\$80 - \$120
Chiropractic X-Ray Studies.....	\$30 - \$280
Chiropractic Adjustments.....	\$25 - \$60

There are several options for paying for your care at our office. Please read the following before choosing the plan that best fits your situation. This information will enable us to better serve you and avoid misunderstandings in the future. If special arrangements are needed, please consult Dr. Land.

Our primary concern is your health and well-being.

### **Plan #1 – Cash** (for patients without insurance or with a high deductible)

Fees are to be paid at the time services are rendered. We accept cash, check, debit cards, or credit cards.

### **Plan #2 – Insurance**

If your insurance covers care in our office, we will bill your insurance company. Until we have received verification from your insurance company, we will collect our “Cash” rate. Once payment is received from insurance, your payment(s) will be adjusted accordingly. Most patients will have a co-pay at each visit and may need to meet a deductible before insurance begins reimbursement.

Medicare patients: We collect our “cash” rate (\$46) at the time of treatment. We bill Medicare and Medicare will reimburse you and forward the claim to your secondary, if applicable.

### **Plan #3 – Prepay plans**

You may purchase a “package” of 12, 24, or 36 adjustments which you pay for in advance.

These plans provide a discount, ranging from 10 – 20%, off our standard rates.

Insurance is not billed. The plans are not sharable or transferable.

### **Plan #4 – Auto Injury**

You need to supply a copy of the accident report, your car insurance declaration page (for Med Pay), and attorney information, if applicable. We do NOT take injury cases on a lien, unless you were referred to us by an attorney. We will bill insurance on your behalf. Until insurance and/or legal information has been confirmed, you will be responsible for payment of your care.

I \_\_\_\_\_, agree to these terms and choose PLAN # \_\_\_\_\_.

Print Name

**I authorize release of medical and other information necessary to process my claim(s). I authorize assignment of payment(s) to Jenna Land, D.C. I understand the amount due for treatment is ultimately my responsibility.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of patient/responsible party