
I understand and agree that health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company. I understand that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me, and 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 me will be immediately due and payable.

It is our office policy to make certain that we provide all persons with a free consultation in order to determine if theirs is a chiropractic problem.

Cost Estimates

Complete Orthopedic/Neurological/Physical Exam	\$150.00
Spinal X-Ray and Exam (Two views)	\$198.00
Spinal X-Ray and Exam (Scoliosis study)	\$75.00
Electrical Therapy	\$25.00
Cold Laser	\$45.00
Acupuncture	\$50.00
Ultrasound	\$30.00
Disc Decompression	\$75.00
Interim/Update Examinations	\$85.00
Adjustment	\$50.00

** All cases vary. The doctor will handle patients from a case to case basis, therefore charges may vary.

If you understand and agree with all of the above office policies, please sign below.

Patient's Signature _____ Date _____

Parent/Guardian Signature _____

Doctor's Signature _____