

ALAN J. NUNEZ, D.C.
NUNEZ CHIROPRACTIC, INC.

FINANCIAL AGREEMENT

All balances are due and payable in full at the time of treatment, unless previous arrangements have been made with this office.

FEE SCHEDULE:

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| 1. | Initial consultation, complete exam, and 1st treatment | \$175.00 |
| 2. | Regular office visit including chiropractic treatment | \$100.00 |
| 3. | Physical Therapy (ultrasound, traction, massage, therapeutic exercise, etc.)
varies per therapy | |
| 4. | X-rays are performed at an outside facility | Fees vary by area x-rayed |
| 5. | Supplements, books and orthopedic supplies | Fees vary |
| 6. | Medicare: Initial exam, and 1st treatment | \$155.00 |
| 7. | Medicare: Regular office visit--chiropractic treatment | \$ 75.00 |
| 8. | Children under 18 and full time students, initial exam and treatment | \$140.00 |
| 9. | Children under 18 and full time students, regular treatment | \$ 75.00 |

INSURANCE:

Chiropractic care is covered by many insurance plans. Patients who carry any form of medical insurance should know that all services furnished are charged directly to the patient and that he/she is personally responsible for payment. Therefore, it is customary to remit payment on the day of treatment. The statement you will receive has all the information needed for you to be reimbursed by your insurance company. Simply attach one copy of each receipt to your insurance form and mail it in.

Personal injury cases are accepted on an individual basis. Each case must be discussed with the office or Dr. Nunez prior to acceptance.

Policy for missed appointments:

1. Rescheduling with 24 hours notice – (48 business hours is preferred) - no charge.
2. Rescheduling to a different time slot during the same day if possible - no charge.
3. Rescheduling to a different day or canceling an appointment without 24 hours notice - \$25.00.
4. Missed appointment with no phone call - \$40.00. Without adequate notification, it can prevent other patients in need from using that time space.

I, the undersigned, have read this financial agreement. I understand that I am personally responsible for full payment of my balance at the time of treatment. In the event that my account is a personal injury claim, and the insurance carrier makes no payment or only partial payment on the claim, I understand that I am personally responsible for the entire balance due. I also authorize the release of any information necessary to process any claims.

Patient's signature _____ Date _____