Touch For Health - Fee Schedule and Financial Plans (Page 1)

We are committed to providing you with the best wholistic care possible in a caring environment and have established our financial policies to achieve that goal. Our goal is to help you move in the direction toward wellness and wholeness-balance body-mind-spirit. After the doctor goes over your recommendations to assist your body in functioning at its optimal potential, you will have the opportunity to ask any questions necessary to help you choose the payment option that works best for you. You will be expected to **pay** for your care **at the time service is rendered** unless other arrangements are made in advance. Other arrangements include our pre-payment bookkeeping discounts, Family Adjustment Plans (FAP), accident insurance coverage, or payments from an attorney. **We gladly accept Cash, Check, VISA, MC, Discover and Care Credit** (Care Credit applications in office)**. 2% processing fee for all credit card transactions over $1,000.**

Service	***Fee***
* ***Initial Chiropractic Exam:*** Including consult, history, computerized Muscle balance & nervous system stress tests, posture evaluation, report of findings, recommendations. * ***Progress Evaluation/consultation:*** (to monitor your progress, as Determined necessary by the doctor or requested by patient) * ***Adjustments***	$150 $50 Birth till 5 years of age $50 $25 birth till 5 years of age $65 or see bookkeeping discounts below
* ***Healthy Lifestyle Coaching:*** Consult/Results & recommendations	$100 initial visit $25 per 15mins
* ***Hyperbaric Sessions (MHBOT) Mild Hyperbaric Oxygen Therapy***	$75 - 60 min & $100 - 90 min **or** see bookkeeping discounts for prepaid sessions
* ***Infrared Sauna Sessions / Packages*** Package A Package B Package C	$1 per minute – minimal $20 $150 – 3 Hours (save $30) $225 – 5 Hours (save $75) $450 – 10 Hours (save $150)
* ***Hair Analysis:*** For mineral deficiency/imbalance and heavy metal toxicity-includes lab work and consultation. * ***Other lab tests: Blood, Urine, Saliva, Dutch Testing, DNA Kits, Allergy/Sensitivities***	$250 Dependent on tests ordered
* ***Rolling Massage Table***	$20 – 15 min ($1 per min afterwards)

Payment Option (1)

______Bookkeeping/pay as you go discount: $50.00 (you save $15 for each adjustment)

Payment Option (2)

______Prepay 6: You pre-pay for 6 adjustments $270 ($45/adj.-you save $20 for each visit)

______Prepay 12: You pre-pay for 12 adjustments $480 ($40/adj.-you save $25 for each visit)

______Prepay 36: You pre-pay for 36 adjustments $1260.00 ($35/adj.-you save $30 for each visit)

Payment Option (3) (MHBOT) Mild Hyperbaric Oxygen Therapy Pre-pay frequent diver plans

______Prepay 10: $600 for 60 min sessions or $800 for 90 min sessions
______Prepay 20: $1100 for 60 min sessions or $1550 for 90 min sessions
______Prepay 30: $1500 for 60 min sessions or $1875 for 90 min sessions
______Prepay 40: $1800 for 60 min sessions or $2400 for 90 min sessions
______Joint Sessions- This package is for any 2 or more people (i.e couples, workout partners, parent/child(ren),etc.) who wishes to have their sessions together, in the same chamber, at the same time. Each additional person is required to pay an additional 50% of the original plan.

(Continue on back)

Touch For Health - Fee Schedule and Financial Plans (Page 2)

Payment Option (4)

______ ***Automobile Accident**: We* will file claims to your insurance company, attorney, or other person's insurance company, **only if** they cover chiropractic care in our office and agree to mail payment to us (at the base rate of $65 per chiropractic adjustment, $100 initial exam, $180 per SEMG and report, and $90 per Infrared Thermal Scan and Report). Therapy is $25 per 15 min. session of intersegmental traction. You will be responsible for any unpaid balance within 30 days of a notice of denial or if max benefits have been exhausted. You will also be responsible at the time of service for any services provided not because of the accident/injury, and all products.

Payment Option (5)

______ ***Family Plan Payment Agreement:***

- First time exams will be half-off regular price for additional designated family members who are not currently patients.
- The total number of adjustments purchased can be used by and distributed between any participating family members.
- Due to the greater bookkeeping discount of these family plans, only one receipt is provided at the time of original payment. ****You are responsible for keeping track of your correspondence and turning in visits to your insurance company for reimbursement as you use the visits.** We will provide you with all necessary insurance codes to file.

Names of participating family members: ______

______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________

Payment schedules for 2-6 family members	
Number of family members	Family Plan Fee, Number of Adjustments and Average Adjustment Price. Based on 26 adjustments per member and number of family members
	$500 per additional family member
2	$2080 (52) $40.00 /adj
3	$2580 (78) $33.08 /adj
4	$3080 (104) $25.19 /adj
5	$3580 (130) $27.54 /adj
6	$4080 (156) $26.15 /adj

****You may choose to discontinue care at any time. There is no time limit to use your prepay visits. If you choose to discontinue care before all pre-paid adjustments/visits are used, your account will be adjusted at the base rate of $65.00 per chiropractic adjustment and $75 per 60 min and $100 per 90 min session for mild HBOT. Meaning, you are no longer under a discounted plan, every session becomes per session price. Any balance due to the office must be paid within 30 days. Refunds will, if applicable, be paid within 30 days.**

****I have read and understand the above policies. I have initialed the one I've chosen. I understand I can choose another plan at any time during my care, after completing previous plan.**

****If an insurance company or attorney is being billed for me, I authorize the release of any medical and/or other information necessary to process this claim for payment.**

Patient Signature ____ Date ____________________

Guardian's Signature ____ Date ____________________

Revised 3/13/24