Disclosure/Agreement of Fees and Payment Policy

The service description is followed by the description first code is the office code; the second code is the CPT code (standard insurance code). As of **January 1, 2017** our service, codes and policy are as follows:

Exams

Examination 15 min to 60 minutes $40.00-$250.00 (Ex1b-5 99201.51-5)

Consultation and re-examination

Consultation/ re-examination 15-30 min $ 40.00-$160.00(Ov1-4;99211)

Laboratory/x-rays

Vary based on laboratory fees. X-rays are covered by outside services

Adjustments

M2	98940	(1-2 areas)	$ 40.00	M3	98941	(3-4 areas)	$ 65.00
M4	98942	(5 areas)	$ 80.00	M6	98943	(extremities)	$ 50.00

Therapies (per 15 minutes or maximum therapeutic value)

T7	97140	Manual Muscle	$ 40.00	T10	97112	Nerve/muscle	$ 40.00
T4	97124	Deep Massage	$ 40.00	T5	97026	Laser	$ 40.00
T9	97012	Mach. traction	$ 40.00	T13	97026	Infrared Sauna	$ 30.00
T6	97110	Muscle rehab	$ 40.00	T12	97114	Gait (walking)	$ 30.00
MS1	30 min massage		$ 30.00	MS2	60 min massage		$ 60.00
	99071	Supplements	Varies				

Initial

____ I have read the above codes and fees and understand the cost of my care with Dr. Steven Shaffer and staff. I understand that I am responsible for payment of all payments related to my care. I also understand there is an **$80.00** charge for missed appointments or those cancelled within less than 24 hours.

____ I understand that if I have a balance for medical services not paid, I will be responsible for a minimum payment of **$80.00** per month of the outstanding balance until paid in full. If my balance is not paid in a timely manner as agreed herein **(60 days)**, I promise to pay interest at the rate of 2% per month on the unpaid balance. In addition, I agree to pay any and all collection, court and attorney fees in the collection of my account.

____ I understand that if my treatment is associated with a personal injury or accident claim, I will be responsible for the payment of all charges incurred regardless of the outcome of my case.

____ I understand that if my insurance company or 3rd party declines payment or any portion of a payment, I am responsible. In addition, I authorize Dr. Shaffer and/or staff to file a Small Claims suit on my behalf against my insurance company as a method of collection. **I further understand that I will be present at the court date, if needed.**

____ I understand that if a check or debit is returned for insufficient funds, I will be charged a **$25.00** service fee, plus any bank charges incurred by Dr. Shaffer.

____ I authorize N.M.C. to bill my credit card on file for **services, products** and **missed appointment fees**.

I have read, and fully understand, the above financial terms and prices and agree to them as stated.

Signed_____ **Date**_____