Office Fee Schedule and Financial Policy

Service	Charges
Consultation	$0
Initial Exam/Computer Scans	$56
Dynamic Exam/Computer Scans	$38
X-Rays (per set) 2 views min.	$55
Adjustment	$28-40
Acupuncture	$45
Laser Therapy	$30
Muscle Stimulation Therapy	$15
Rehabilitation Exercise Program	$20
Nutritional Counseling	$35
Ultrasound	$25
Spinal Decompression	$50 per session
X-Ray Consult	$30-$100
Urinary Analysis	$10

Financial Policy and Chiropractic Active Life Plans:

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange an Active Life Plan in advance. Active Life Plans include yearly Corrective Adjustment Plans (CAP), monthly CAPs, weekly CAPs, or extended payment plans. These Active Life Plans are designed to be the most cost effective to keep you and your family as healthy as possible. Details of these plans will be discussed with you during your Chiropractic Report.

I fully understand that I am financially responsible for and agree to pay all charges not paid by my health care coverage, including deductibles, co-insurance, and payments from insurance companies sent to me directly. In consideration of the chiropractic services furnished to me, I hereby agree to pay Back to Health Chiropractic Center LLC any balance due within ninety days from presentation of my bill. In the event of default I promise to pay legal interest on Indebtedness together with 50% collection costs and attorney fees as may be required to effect collections.

Health Insurance:

If you have insurance that covers chiropractic and you are like most of our patients and choose to participate in one of our Active Life Plans we will file your insurance for you. We will also call to verify your insurance coverage for you, however, remember your agreement with your insurance company is between you and them.

I have read and I understand the above policy. I have initialed the one that applies to me.

Patient Signature _____ Date_____

ASSIGNMENT OF BENEFITS/ERISA AUTHORIZED REPRESENTATIVE FORM

Back to Health Chiropractic Center LLC

Financial Responsibility

I have requested professional services from Back to Health Chiropractic Center LLC Dr. Melani Crocker D.C. on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advice.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to the said Dr. Melani Crocker D.C. I certify that the health insurance information that I provided to Dr. Melani Crocker D.C. is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Dr. Melani Crocker D.C. to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Dr. Melani Crocker D.C., in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Dr. Melani Crocker D.C. directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Dr. Melani Crocker D.C., I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Dr. Melani Crocker D.C. upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Dr. Melani Crocker D.C.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Dr. Melani Crocker D.C. are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Dr. Melani Crocker D.C. to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatment: (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Dr. Melani Crocker D.C. to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plain: (1) the right and ability to act as my Authorized Representative in connection with any claim, right or cause in action that I may have under such insurance policy and/or benefit plain; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right or cause of action in connection with said insurance policy and/or benefit plain (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I receive from Dr. Melani Crocker D.C. and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Print Date

_____ _____

Policyholder/Insured Signature Date