Bull Family Chiropractic, LLC Fee Schedule and Payment Options

CPT Code	Description	Full Rate	Discounted Rate
99202	New Pat. Exam Level 2	$ 70.00	$ 15.00
99203	**New Pat. Exam Level 3**	**$ 100.00**	**$ 15.00**
99212	Re-Exam Level 2	$ 42.00	$ -
99213	Re-Exam Level 3	$ 70.00	$ -
98940	Adjustment 1-2 Segments	$ 30.50	$ 30.50
98941	**Adjustment 3-4 Segments**	**$ 40.00**	**$ 35.00**
97124	Massage - 15 mins	$ 22.00	$ 18.00
97039	Laser Therapy	$ 15.00	$ 10.00
97110	Stretching	$ 27.00	$ 10.00
97140	Graston	$ 28.00	$ 10.00
99050	After Hours Visit	$ 25.00	$ 25.00
*****	Rock Taping	$ 20.00	$ 15.00
*****	Reflexology - 45 mins	$50.00	$50.00

Payment Options

Option 1 - Cash Patient with Payment at Time of Service

A cash patient has no insurance or elects to not have their insurance billed. **Payment is expected at time of servic**e. If payment is made at time of service, a cash patient may take advantage of all discounts listed in the discount column.

Option 2 - Insurance Patient with Payment at Time of Service

An insurance patient that wishes to have Bull Family Chiropractic bill their insurance company may elect to make payment at the time of service. If patient elects to make payment at time of service, the patient will be billed at the discounted rate. The insurance company will be billed at the full rate. Should the insurance company reimburse for services, the patient will be reimbursed the amount they paid on the day of services less any applicable co-pays. Should the insurance company not reimburse due to either non-covered services or the amount is applied to the patient's deductible, the patient pre-payment will be applied to the charges and no further payment will be necessary.

Option 3 - Insurance Patient with No-Payment at Time of Service

An insurance patient that wishes to have Bull Family Chiropractic bill their insurance company while only **paying copayment amount will have their insurance company billed at the full charge rate**. Should the insurance company not cover the charges either for non-covered services or apply the charges to the patient's deductible the full amount of charges billed will be the responsibility of the patient with no discounts being applicable.

Option #:

Patient signature _____ Contract Date _____ Staff INC_____