



Financial Policy

For your convenience, we accept cash, check, debit cards (including FSA & HSA), and credit cards (Visa, MasterCard, Discover). For those concerned with being able to afford care, we have payment plans and hardship options available. Eligibility is determined on a case by case basis, so if you have special financial circumstances, please ask us for more information.

Our fees are determined based on the amount of time spent with the doctor. The following is an estimate of our basic fee schedule:

Consultation (15-30 minutes):	\$ 50 – 150	Re-examination (30 minutes):	\$ 75
New patient exam only (60 minutes):	\$ 170	Nutrition Eval./Supplement Testing:	\$ 50 – 150
Chiropractic Treatment (30 minutes):	\$ 75	Gait/Shoe/Biomechanics Evaluation:	\$ 75
Acupuncture only (30 minutes):	\$ 55	Counseling (Nutrition, Preventative):	\$ 50 – 150

There will be a separate fee for all dispensed items such as nutritional supplements, orthotics and laboratory tests. Payment is expected in full at the time that services are rendered.

I understand that I do not have insurance or have chosen not to have Kinesis Healthcare bill my insurance for their services. I thereby release Kinesis Healthcare from billing any third party for coverage of services. Any future insurance billing of these visits will not be the responsibility of Kinesis Healthcare.

I understand that I will be provided with a Superbill containing all codes and information necessary for me to apply for reimbursement from my insurance company. I understand that my eligibility for reimbursement depends upon the specifics of my insurance plan. I understand that if I have questions about my plan, deductible, or policy limits, I may ask Kinesis Healthcare for an Explanation of Benefits (EOB).

I understand that 24 hour advance notice is required to cancel an appointment to avoid a \$ 50 cancellation fee. I consent to Kinesis keeping my current credit card information on file, to be used only in the event that this cancellation policy is abused.

I, _____, understand and agree to the above policy.
Print Name

Signature (of Parent or Guardian if a minor)

Date

Credit Card Type: Visa MasterCard Discover

Name as it appears on card: _____ Card # _____

Expiration Date _____ Billing Zip Code _____ CVV _____ (3 digit code on back)