SANCHEZ CHIROPRACTIC CENTER, P.C.

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FEES

Our office has established a policy to be compliant with the No Surprise Act of 1/1/2022 which allows our fees to be transparent to our patients in writing. Once we have assessed you in our consultation which is complimentary, the list below is the itemization that you are responsible to pay today. Due to HIPPA, the Office of Inspector General, and the No Surprise Act 2022, our office **DOES NOT** allow discounts, family plans, or any installment options. If we are providers for your insurance, your insurance has negotiated its fee schedule from these prices. If you run out of benefits or if a service is not covered by your insurance, the prices below are the charges for the services without insurance. Please remember your insurance states to our office when we call, "***A quote of benefits and/or authorization does not guarantee a payment or verify eligibility. Payment of benefits is subject to all terms, conditions, limitations, and exclusions of the member's contract at the time of service.***"
We will not know if your insurance will pay for the recommended services until the claim has been processed and an Explanation of Benefits (EOB) is sent to us. The total amount is the highest amount that we will charge. We will provide an "X" or a checkmark for an item that we are intending to provide your specific case.

_____$130.00 ---Examination – 99203 – 20 to 30 minutes

_____$ 95.00 --- Examination – 99202 ---15 to 20 minutes or less

_____$ 55.00 ---Re-examination –99213, 99212
(Only applies to patients who have been previously seen in the last 2 years or more recently.)

_____$ 50.00 ---1 radiology view (x-ray) --72020

_____$100.00 –2 radiology views (x-ray)—72040 or 72100 (neck or lower back)

_____$100.00 – 2 radiology views (x-ray) – 72070 (chest)

_____$150.00—3 radiology views (x-ray)—72020 with 72040 (neck)

_____$ 45.00 – 1-2 regions adjustment (spinal manipulation) –98940

_____$ 55.00 – 2-4 regions adjustment (spinal manipulation) –98941

_____$ 45.00—1 extremity adjustment –98943 (example: shoulder, wrist, knee, feet, etc.)

_____$ 45.00– each therapy –97140 (electrical, Biofreeze applied, interferential)

_____$ 46.00 – lumbar support belt

$_____ == **Total amount due** (GFE-Good Faith Estimate)
You are required to sign and date below acknowledging the total price, which was made clear to you, verbally and written, during this visit. You are agreeing that you understand our total fee, financial policy, and you had all questions answered before signing. You are also agreeing that you are of legal age or have legal representation to sign on your behalf, not under any duress and with a sound mind, and not going through bankruptcy at this time of signing the document. You have also signed the financial agreement prior to this document that if you do not pay this amount in full, you are liable for a 40% increase to the total amount due for coverage of collection fees, court costs, and other expenses/penalties.

Signature or legal representation_____Date _____