

TOYOS CHIROPRACTIC & WELLNESS CENTER
4515 N 32nd St. Suite 110 Phoenix, AZ 85018

FINANCIAL ARRANGEMENT & AGREEMENT

We believe that every patient has the right to expect from us the very best in professional care. In turn we feel we can expect your cooperation in establishing a definite financial arrangement and agreement. The fees below are the reduced cash plan amounts for uninsured individuals.

THE FOLLOWING SELF-PAY PLANS ARE AVAILABLE: The fees in < > are the reduced cash plan amounts. Our fees are reduced because payment is made at the time of service.

- | | | |
|---------------------------------------|----------------------------|----------------|
| 1. CHIROPRACTIC: Minimal Office Visit | \$45.00 - \$ 83.00 / Visit | <\$30 - \$40> |
| 2. EXAMS: (Neurological Scans) | \$123.00 - \$155.00 | <\$80 - \$155> |
| 3. EXERCISE: | \$42.00/ Exercise | <\$30> |
| 4. MASSAGE: | \$ 80.00 - \$ 120.00 | <\$55 - \$65> |

WE NOW OFFER FINANCIAL THROUGH CARE CREDIT FOR ALL OUR SERVICES

- All fees and Plans are subject to change at any time. Re- evaluating exams are done every 12 – 20 visits, with injury and if your care should lapse for three months or more. Also, if your care should lapse the terms of this plan will be null and void.
- Should you discontinue care with any prepay money involved, the normal fees will apply on all prior visits. If there has been an over payment monies will be refunded.
- All Cash Plan fees are applicable to clinic hours only. Emergency visits are additional (\$50 After hours / Emergency plus the minimal office visit)
- The clinic will NOT provide any reports, diagnoses, X-rays, or insurance claims on past or current charges. From the date you notify us that you want your insurance billed, we will bill from that date forward only at normal office fees.
- Receipts or monthly or annual statements will be issued on limited basis. Finance charge of 1.5% per month A.P.R. 18% will be assessed on all accounts over 30 days.
- Should patient be involved in an accident injury whether it be work related or personal, this agreement shall become null and void and new arrangements made.
- Medical Records Disposal Protocol: An office policy, medical records will destroy six years after your last visit.
- If a check is returned for insufficient funds, there will be a \$25 service charge. I understand if my balance is not paid per my financial agreement, I promise to pay any and all collections, court, and attorney fees in the processing of my account. A 30% collection fee will be assessed on all outstanding balances.

Integrity Agreement: Both parties desired to have a method of resolving discomfort, misunderstanding, or disputes, if any should occur, privately, quickly economically, and in a friendly, educational manner. We, therefore, agree to resolve these matters using the communication, negotiation and mediation and arbitration procedures set forth in the latest edition the standard Law Form Integrity Agreement.

I authorize the Doctor at the Center to examine, take X-rays if necessary, and treat me for the care and management of my condition. I hereby understand agree to the Financial Arrangement and Agreement as it has been explained.

Date: _____ Patient/ Parent Signature: _____
Witness: _____ Print Name: _____

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99202	New Patient Evaluation and Management	\$88.00
99203	NP-Detailed History and Examination	\$123.00
99204	NP-Comprehensive History and Examination	\$155.00
99205	NP-Comprehensive History & Examination	\$225.00
99212	Established Patient Office Visit	\$49.00
99213	Est. Pt- Expanded History and Examination	\$68.00
99214	Est. Pt-Detailed History and Examination	\$103.00
99215	Est. Pt-Comprehensive History & Examination	\$159.00
98940	Chiropractic Manipulative Treatment 1-2 Regions	\$55.00
98941	Chiropractic Manipulative Treatment 3-4 Regions	\$67.00
98942	Chiropractic Manipulation Treatment 5 Regions	\$83.00
97010	Hot and Cold Packs	\$22.00
97012	Mechanical Traction	\$32.00
97530	Therapeutic Activities - per unit	\$53.00
97110	Therapeutic Procedure - per unit	\$43.00
97112	Neuromuscular Reeducation – per unit	\$42.00
97750	Physical Performance Test – per unit	\$85.00
97535	Activities of Daily Living (Home)	\$35.00

I have read the above codes and fees and understand the cost of my care with my treating doctor. Some companies pay fixed allowances for certain procedures and other pay a percentage of the charge. I understand that I am responsible for payment of all deductibles, co-insurance and co-payments related to my care. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the above fee scheduled regardless of the outcome of my case. This office will not accept any PPO/HMO as payments in full for services performed related to third party injuries. Therefore, this office will not bill any health insurance for any services performed with regard to this injury except under special circumstances. I also understand if this is a personal injury claim an Arizona lien is processed and recorded promptly with the Maricopa Recorder's Office. There is a fee for this filing and will be added to my account balance. I understand if my balance is not paid per my financial agreement, I promise to pay any and all collections, court, and attorney fees in the processing of my account. A 30% collection fee will be assessed on all outstanding balances.

Finance charge 1 ½ % per month / A.P.R. 18% will be assessed on all outstanding accounts. If copies of x-rays are required there may be a copy fee of \$ 15.00 per frame to be paid prior to said copy. Should I discontinue my care, I understand and agree that my entire balance is due immediately. I understand that if a check is returned for insufficient funds, I will be charged a \$25.00 service charge

Medical Records Disposal Protocol: As office policy, medical records will destroy six years after your last visit.

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I have read fully and understand the above financial terms and prices

Signed _____

Date _____