



FEE SCHEDULE

Please check each box as read.

- | | |
|---|-----------------------------------|
| <input type="checkbox"/> Initial New Practice Member Visit | 150 |
| Includes consultation, brief history, exam & Adjustment | |
| <input type="checkbox"/> Adjustment session | 49 |
| <input type="checkbox"/> Re-evaluation after 6-12 sessions | 49 |
| <input type="checkbox"/> Nutrition Evaluation | 49 |
| <input type="checkbox"/> Report of Findings | included in 2 nd visit |
| <input type="checkbox"/> Wellness Package Program is advised to ensure commitment. Details provided at time of Report of Findings. | |
| <input type="checkbox"/> This office does not accept or process any insurance plans. | |
| <input type="checkbox"/> Patient information is confidential and is released only with your written permission. | |
| <input type="checkbox"/> Appointments are charged without 24 hour notice with exception of weather or situations beyond control. | |
| <input type="checkbox"/> Any outstanding balance on account will be charged to your credit card on file with written notification of charges. | |

I have read, understood and agree to financial responsibility.

Signature _____ Date _____