DISCLOSURE OF FEES/PAYMENT POLICY

99203	Detailed Exam	$175.00
99204	Comprehensive Exam	$175.00
99213	Intermediate Visit	$65.00
99214	Extended Visit	$85.00
99215	Comprehensive Visit	$130.00
98940	CMT spinal 1 to 2 regions	$65.00
98941	CMT spinal 3 to 4 regions	$65.00
97010	Cryotherapy	$5.00
97014	Electrical Stimulation	$25.00

I have read the above codes and fees and understand the cost of my care with my treating doctor. I understand that I am responsible for payment of all my care. I understand that if
I have a balance for medical services not paid, I will make a minimum payment of $50 each month or 20% (auto debit) of the outstanding balance, whichever is greater. If my balance is not paid in a timely and monthly fashion, I promise to pay any and all collection, court, and attorney fees in the collection of my account. 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 schedule regardless of the outcome of my case. Payment is due on day of services rendered for accident cases. I understand that if a check or debit is returned for insufficient funds, I will be charged a $25.00 service charge.
I further understand that if my insurance company declines payment, I authorize Dr. Carnahan to file small claims on my behalf against my insurance company as a method of collection. I further understand that I will be present at the court date if needed.

I have read and fully understand the above financial terms, fees and agreement.

Signed_____ Date_____

I understand that this office does not accept Medicare as payment and the doctors do not treat Medicare patients. I certify that I am not currently covered by Medicare. If I become covered by Medicare at a future date, I will notify the office immediately.

Signed_____ Date_____