Welcome to our Office!

Thank you for choosing Hardin Chiropractic as your chiropractic healthcare provider. We are committed to make your treatment program a success.

We offer the following services:
• Consultation and Examination
• Family care for children and adults of all ages
• Treatment for Auto and Work-related injuries

Office Policy

Fee Schedule	Fees	Medicare Rates	Time of Service Discount
• Initial Exam	$57	$40.00	$40.00
• Chiropractic Fullspine Adjustment (Including trochanter)	$50	$34.42	$35.00
• Myofascial Trigger Point Release	$21	$15.00	$15.00
• Extremity Adjustments	$30	$21.00	$21.00
• Electrical Muscle Stimulation	$21	$15.00	$15.00
• Ultrasound	$21	$15.00	$15.00
• Heat/Ice Therapy	$10	$ 7.00	$ 7.00
• Infrared Therapy	$14	$10.00	$10.00
• Traction	$21	$15.00	$15.00
• Therapeutic Exercise	$21	$15.00	$15.00
• Acupuncture for pain relief	$42.50	$30.00	$30.00
• Massage/Cupping	$42.50	$30.00	$30.00
• Muscle Testing	$42.50	$30.00	$30.00
• Follow up Exams	$47	$28.00	$28.00

Missed Appointment Policy

This office reserves the right to charge for missed appointments unless canceled at least 24 hours in advance. Our missed appointment fee is $35. Patients will receive two warnings before they are charged the fee. Insurance plans will not pay for this charge so please help us serve you and our other patients better by keeping scheduled appointments or canceling 24 hours in advance.

Patient Financial Policy

At Hardin Chiropractic, we understand that the cost of healthcare is a key concern for our patients. Although patient care is our main priority, we hope that you will assist us by understanding your responsibility as it relates to our Financial Policy. If you have any questions regarding our policy, a member of our staff will be glad to assist you.

1. Full payment of patient obligation is due at the time services are rendered. We accept cash, personal checks and MasterCard/Visa as forms of payment. It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately, the patient is responsible for all services, including those not reimbursed by third party payors (insurance company).
2. All insurance assignment patients must pay their deductibles in full and the co-payment at the time of service. All insurance checks and payments will be assigned to our office. If you mistakenly receive an insurance check in your mail, please bring the check and all attached paperwork to our office so that we may properly credit your account.
4. Returned check fee is $25.00.

INSURANCE POLICY

1. The privilege of insurance assignment begins when our office receives your insurance forms. You are considered to be a cash patient until our office qualifies your coverage to determine the extent of benefits under your policy. Usually by the second visit.
2. Due to frequent erroneous information when qualifying benefits, in the event that your insurance company does not comply with the coverage that is quoted to us, you are ultimately responsible for payment.
3. Once your treatment plan has been completed or you have reached maximum therapeutic benefit, you will be considered under maintenance or supportive care. Most insurance policies will not pay for these services. However if you have a flare up or a new condition please inform Dr. Hardin and she will start a new treatment plan.
4. Should you discontinue care for any reason other than discharge by the doctor, any and all balances due will become immediately payable in full, regardless of any claims submitted.
5. This office does not promise that an insurance company will reimburse you for the usual and customary charges submitted by this office, we will expect you to assist in any dispute with an insurance company over the amount of reimbursement.
6. Since we do not own your policy, and, occasionally, we experience difficulty in collecting from the carrier, we may ask for your active assistance in rectifying this situation.

It is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health care, or any of our policies, please let us know. We look forward to your referrals and to a doctor-patient relationship that works for our mutual benefit.

I have read, understand and agree to this Financial Policy in its entirety.

_____ _____

Print Patient Name **Date**

_____ _____

Patient Signature or Responsible Party **Date of Birth**

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Full Name _____

Patient's Signature or Parent/Guardian_____

Date_____