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| **Care plan & AGREEMENT FOR SERVICES** |

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Office/Telehealth Visits***

\_\_\_\_\_ visits per week for \_\_\_\_\_ weeks (\_\_\_\_ visits x $\_\_\_\_\_ per visit) $00.00

\_\_\_\_\_ progress visits (\_\_\_\_ visits x $\_\_\_\_\_ per visit) $00.00

\_\_\_\_\_ corrective care visits (\_\_\_\_ visits x $\_\_\_\_\_ per visit) $00.00

**Total number of *office / telehealth visits*: up to \_\_\_\_\_ visits over \_\_\_\_\_ months $00.00**

***Diagnostic Testing***

Imaging as indicated ($\_\_\_\_\_\_ per x-ray view) $00.00

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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | $0.00 |

**Total testing cost $0.00**

*Retesting can be important and additional tests may be recommended at the additional per test cost listed above.*

**Other Products & Services**

Chiropractic health modalities (\_\_\_\_ x $\_\_\_\_ per modality) $0.00

Exercise and Nutrition Plan $0.00

Orthotics - 1 pair $0.00

Cervical pillow - 1 $0.00

Nutritional detoxification – 1 $0.00

Massage (\_\_\_\_ x \_\_\_\_\_\_ per 15 minute massage) $0.00

**Total cost of other services $0.00**

**Total costs you will incur for services pursuant to the Plan: $000.00**

This Plan includes the visits, testing and other services listed above. The content of any specific visit is determined at the time, based on presentation. A history, physical examination, and diagnosis according to generally accepted standards is required prior any prepaid plan. Our office has adopted a fee schedule for each service provided. The fees outlined in this plan are discounted from our usual and customary fees. If additional services or products are recommended or requested, associated costs will be explained in advance.

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| **Item** | **Cost** | **TOTAL** |
| ***Office / telehealth visits*** | $00 initial visit  $00 initial follow-up  $00 x 8 provider visits + 2 | $0.00 |
| ***Diagnostic testing*** | See itemization above | *$0.00 estimated* |
| **Other Services** | See itemization above | $00 |

**TOTAL cost $00.00**

**Method and timing of payments:**

\_\_\_\_ Full payment at the discounted amount of $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cash, check, credit card)

\_\_\_\_ No interest monthly payments of $0.00 on or before the 1st of each month for 3 total months.

\_\_\_\_ Credit card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ exp. \_\_\_\_\_\_\_\_ Code \_\_\_\_\_\_

\_\_\_\_ I will pay by check each month

\_\_\_\_ Insurance, with balance billing (see *Billing Rights and Obligations* below).

**Refund Policy**

Your decision to participate in any health care is voluntary, and you can stop at any time. Your provider may also recommend that services stop early, or make alternate recommendations. Special circumstances such as extended absences, injury, or illness may prevent you from receiving services as planned. You will not be charged for services you do not receive and you will be refunded for any unused, prepaid services within 30 days of a decision to terminate care.

For example, if you are out of town, become ill or are unable to participate in your Plan, the time of your plan will be automatically extended. If, however, an illness or new injury (e.g. work, auto, fall, accident, etc.) or other change occurs preventing a simple extension, your provider will make recommendations and explain any related costs. You may choose to participate in a modified Plan or to discontinue services. If care is discontinued for any reason and you received some, but not all, planned services or products, you are responsible for payment for what is received at the rate set forth above. If you pay in full to initiate care and discontinue after only portion of planned products and services, you are responsible for payment for the visits completed at the per visit rate and any tests performed and products purchased. As an example:

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| --- | --- | --- | --- |
| Planned | **Item** | **Cost** | **TOTAL** |
|  | ***Office / telehealth visits*** | $0 initial visit  $0 initial follow-up  $0 x 4 provider visits + 2 | $00.00 |
|  | ***Diagnostic testing*** | See itemization above | *$0.00 estimated* |
|  | **Other Services** | See itemization above | $0.00 + *$00.00 estimated* |

|  |  |  |  |
| --- | --- | --- | --- |
| Term 2 mos. | **Item** | **Cost** | **TOTAL** |
|  | ***Office / telehealth visits*** | $0 initial visit  $0 initial follow-up  $0 x 3 provider visits | $0.00 |
|  | ***Diagnostic testing*** | See itemization above | *Cost of tests performed* |
|  | **Other Services** | See itemization above | $0.00 + *supplements* |

**Total Refund: $**

**Billing Rights and Obligations**

Our services may not be covered by insurance or other benefits. Insurance and other benefits are agreements between you and your insurer/benefit provider. You are responsible for confirming information about coverage. We may check benefits and bill insurance as a courtesy; however, there is no guarantee or representation about coverage.

If you are covered by health insurance, you are strongly encouraged to consult with your health insurer to determine accurate information about your financial responsibility for a particular service delivered by a health care provider in this office. If you are not covered by insurance, you are encouraged to discuss payment options prior to receiving services at this office. If you have questions about payment options, think that you have received a bill in error, you want to file a complaint, or have further questions, you can contact:

[Name]

[[email]](mailto:drlauraduke@hotmail.com)

000-000-0000

**No Guarantee:** We make no claim or representation of a guarantee of results, outcome, or the cure of any condition. There is no guarantee that you will achieve any specific results or outcome, or that any condition will be cured or improved.

**By signing you agree that you have** **read, discussed, been offered a copy of, and understand the plan (2 pages) described above and associated costs. You understand and choose to participate in this Plan, knowing the risks and benefits and alternatives, which have been explained.**

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Patient or Person with Authority to Consent Date