**Patient Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Brantley Chiropractic, P.C.**

420 West Avenue

North Augusta, SC 29841

(803) 202-0202 Fax: (803) 202-0201

**FINANCIAL POLICY AND AGREEMENT**

**NO SURPRISE ACT**

Thank you for choosing Brantley Chiropractic, P.C. for your chiropractic needs. Our office is committed to making your chiropractic experience as comfortable as possible. Please, take your time and read the following financial policy carefully. Feel free to ask any questions that may arise concerning our policy.

The **No Surprise Act** is an estimate of charges while on a treatment plan. After 30 days, there will be a re-assessment

($ 30.00 - $ 80.00) in addition to the visit cost to determine your level of care. This estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. Actual costs may differ, or additional treatment may be required.

Initial Visit Between $ 310.00 Back $ 415.00 Neck $ 530.00 Both

Approximately 5 to 10 visits between: $ 60.00 - $ 92.00 per visit

Adjustment “reasonable and necessary” Fees per visit below:

**$60.00 - 98940 1-2 levels adjusted**

**$67.00 - 98941 3-4 levels adjusted**

**$75.00 - 98942 5 or more levels adjusted**

Extra Spinal Manipulation $ 15.00

I understand that I am responsible for the entire account. I shall pay all monies to Brantley Chiropractic, P.C., and I also acknowledge that it is my full responsibility to pay 100% of balances owed to cover collection fees, if sent to a Collection Agency, plus court cost and any interest incurred if litigated upon.

We are only required by law to file Medicare. However, if you have insurance, we will be glad to explain how you can file your insurance. We are out Non-Participating Providers (**out-of-network**) for all insurance providers.

We do not accept assignment from Medicare, but we will file for you.

You are responsible for payment at **time of service**. For your convenience, we gladly accept Discover, Visa, MasterCard and American Express.

I have also received a copy of Consent for Use or Disclosure of Health Information form.

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Patient Print Name Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

or Authorized Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*PLEASE TURN OVER**

Authorized Provider Representative Signature/Date

**Required Disclaimer**

I understand that I am responsible for the entire account. I shall pay all monies to Brantley Chiropractic, P.C., and I also acknowledge that it is my full responsibility to pay 100% of balances owed to cover collection fees, if sent to a Collection Agency, plus court cost and any interest incurred if litigated upon.

This Good Faith Estimate (No Surprise Act) shows the costs of items and services that are reasonably expected for your health care needs for an item or service while on a treatment plan. The estimate is based on information known at the time the estimate was created. This estimate is not a contract, nor does it bind you to use this office or these services.

The Good Faith Estimate (No Surprise Act) does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. Actual costs may differ, or additional treatment may be required. If this happens, federal law allows you to dispute (appeal) the bill, if you choose.

**If you are billed for more than this Estimate, you have the right to dispute the bill.**

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call [1-800-985-3059]. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call

[1-800-985-3059].

*Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.*

I have read and understand Good Faith Estimate and the affects it may have on any supplement or secondary policies. I am aware that I will be responsible for any charges.

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Print Name Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Authorized Provider Representative Date

Please advise office staff if you would like a copy for your records.