**Brantley Chiropractic, P.C.**

420 West Avenue

North Augusta, S.C. 29841

**Please be aware of the following Medicare Regulations concerning Chiropractic Care**

In accordance with the Medicare Act Section 1842 (i), this letter is to advise you that Medicare will only pay for services that it determines to be “reasonable and necessary” under Section 1862(a)(i) of the Medicare Act. If Medicare determines that a particular service, although it would otherwise be covered, is not “reasonable and necessary,” under Medicare program standards, Medicare will deny payment for that service.

* **Medicare limits chiropractic reimbursement to manual manipulation. Reimbursement is based on medically necessary correction care only. Maintenance care is not covered.**
* **Medicare DOES NOT reimburse for charges of exams, x-rays, therapy, extremity adjustments, supplements or supports from a chiropractor. However, it may be required to update your condition should a new course of treatment be initiated.**
* **Medicare patients’ will be responsible for all charges incurred. Our office will file your claims for you and reimbursement from Medicare will be assessed based on 80% of allowable Medicare limiting charge of manipulation only if deemed necessary.**

As a courtesy, we will gladly file your Medicare insurance. However, we do not accept assignment which means we do not accept insurance payments. If any payment is paid, it will be sent to the insured. We do not file Medicare Advantage plans since we do not participate with them, but we will gladly provide you the proper documentation to file.

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.

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

Approximately 5 to 10 visits between: $ 29.00 - $ 65.00 per visit

Adjustment “reasonable and necessary” Fees per visit below:

**$29.00 - 98940 1-2 levels adjusted**

**$42.00 - 98941 3-4 levels adjusted**

**$54.50 - 98942 5 or more levels adjusted**

Extra Spinal Manipulation $ 24.29

After 30 days, if goals are met and services are then determined to be maintenance

“not reasonable and necessary”,

 your estimated charges will be as follows per visit:

**$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 $ 24.29

* **PLEASE TURN OVER**

**Required Disclaimer**

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 **Medicare** coverage /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

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Signature of Authorized Provider Representative Date

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