EXPRESS YOUR HEALTH
FINANCIAL POLICY

Dr. Wells will bill for rendered services according to Federal guidelines. Services are determined at the time of treatment and the patient is responsible for any amount not paid by insurance. We will bill your insurance for services rendered in the office. We will check your benefits, but the benefits quoted are not a guarantee of payment.

AUTHORIZATION TO RELEASE INFORMATION: We will release any information deemed appropriate concerning your physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by you as a result of professional services rendered by Express Your Health, including designated associates and assistants. We are released of any consequence thereof. We are authorized to exchange necessary medical records and discuss continued care with other providers to include referring physician, primary care physician, urgent care facilities, emergency room facilities, as well as specialists that Dr. Wells/Dr. Fedewa/Express Your Health refer to for the purpose of coordinated care.

ASSIGNMENT OF PAYMENT: Your attorney and/or insurance company are hereby requested to pay direct to Express Your Health any monies due on your account, the same to be deducted from any settlement made on your behalf. Further, it is understood that you, the undersigned, agree to pay the full amount of the charges, should your condition be such that it is not covered by your policy or if for any reason the insurance company and/or attorney refuses to pay your claim.

MEDICARE ASSIGNMENT: You authorize any holder of medical or other information about you to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. You permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to yourself or to the party who accepts assignment below. **Medicare only covers manipulation of the spine. All other services are not covered and will be your responsibility.**

We perform manipulation as well as therapeutic exercises to speed recovery and decrease the need for care. You can expect to see these charges on your statements.

Most Common Services	Billed Fees
New Patient Examination	$51-$121
Established Patient Re-evaluation or new examination	$52-$122
Spinal Manipulation	$39-$68
Therapeutic Exercise & Neuromuscular Re-education	$39-$41/ 15 minutes

Orthopedic Supports
Lumbar Pillow $18 (with tax)
Foam Roller $33 (with tax)

FINANCIAL HARDSHIP: We have available discounts for those who meet state and federal poverty guidelines or special circumstances. To qualify for a financial hardship, you must fill out paperwork and provide verification of income.

PATIENTS WITHOUT INSURANCE COVERAGE: Specific non-covered by insurance services may qualify for a time of service discount. To receive the time of service discount, you must pay for these services at the time of your visit.

PERSONAL INJURY/WORKERS COMPENSATION: It is your responsibility to provide our office with the documentation to prove a valid claim, as well as the name of the company, adjuster, or attorney's name. You must also provide the claim numbers and mailing address to send bills. If you fail to provide the documents needed, your case will be converted to cash, and all payment will be due upon receipt.

AUTHORIZATION

I accept and agree to this financial policy. I hereby acknowledge that I am receiving (or about to receive) health care services at Express Your Health and that I have been advised that you are willing to wait for payment for these services provided that there continues to be a reasonable chance that payment will be made either by the insurance proceeds or out of the settlement of a liability case.

I understand that if it is determined: that there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to Express Your Health, or to make other provisions for the protection of the interest of Express Your Health, or if a liability claim exists and my attorney refuses to agree to protect the interest of Express Your Health, or if I have not engaged the services of an attorney: then payment of services at Express Your Health will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever occurs first.

I, the undersigned, a patient in this office, hereby authorize Dr. Leighia Wells/Dr. Valerie Fedewa to administer such treatment as is necessary, and to perform the following therapy and manipulation and such additional therapy or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment. I hereby certify that I have read and fully understand the above authorization for Chiropractic treatment, the reasons why the above named treatment is considered necessary, its advantages and possible complications, if any as well as possible alternative modes of treatment, which were explained to me by Dr. Leighia Wells/Dr. Valerie Fedewa. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

RECORD RELEASE

As a professional courtesy, I authorize Express Your Health to provide my primary care physician and/or my referring physician with reports for my medical record. I also authorize my physician and Dr. Wells to discuss my care.

Minor Child Authorization

In presenting my son/daughter/legal ward for diagnosis and treatment under 18 years of age, I hereby voluntarily consent and authorize Dr. Leighia Wells/Dr. Valerie Fedewa to perform diagnostic tests and render chiropractic adjustments and other treatment as may be necessary with or without my presence.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.