KIEKHOEFER CHIROPRACTIC
8619 West Point Douglas Rd., Suite 110
Cottage Grove, MN 55016
651-458-0094

FINANCIAL POLICY

Welcome to our office! It is our mission to serve you to the best of our ability.
Please read our financial policy then sign and date it below. Thank you.

It is necessary for our office to have a copy of your insurance card(s) in your file. It is your responsibility to notify our office of any changes in your insurance carrier(s). We will verify your insurance coverage. However, insurance companies do make errors in reporting the coverage and benefits. They also have a disclaimer and state "this is not a guarantee of payment until we actually receive a claim". We will file your claims with your insurance. However, it must be understood that your insurance contract is between you (the patient), and your insurance company.
You are responsible for any amount not paid by your insurance company.

Our office does not guarantee your insurance company will pay your claims. If you fail to respond to the insurance company's request, you will be responsible for the full amount.

***Copays are due on the same date of service*.** If this office needs to bill you for unpaid copays, you will be assessed an additional $5.00 billing fee per monthly statement.

Medicare Patients

Chiropractic non-covered services:	Reason Medicare may not pay:	Estimated cost:
1) Chiropractic Examinations	Items 1-5 are non-covered services and items	1) $40.00 to $80.00
2) Chiropractic X-Rays	under Medicare when delivered and/or	2) $60.00 to $120.00
3) Chiropractic Extra-spinal Adjustments	ordered by a Doctor of Chiropractic	3) $30.00
4) Therapy such as ultrasound, electric stim., Intersegmental traction and rehab		4) $20.00 to $25.00
5) Nutritional Supplements, ice packs, pillows, and biofreeze		5) $1.00 to $100.00
6) Spinal Manipulation	6) Medicare may construe your spinal Manipulation to be maintenance care	6) $45.00 to $63.00

Delinquent accounts will be turned over to our Collection Agency.

I have read the above policies and agree I am responsible for any amount not covered by my insurance company.

PRINT PATIENT NAME _____ Date _____

Patient/Guardian Signature _____