Integrative Health & Wellness
Lewiston Family Chiropractic

Disclosure of Fees / Payment Policy

Chiropractic Care		
Initial Exam	98.00	
Re-Exam	75.00	
Adjustment		
1-2 Region	45.00	
3-4 Region	45.00	
5 Region	47.00	
Extra Spinal	32.00	
Therapy / Modalities		*May not be covered by insurance*
Heat/ Ice	5.00	
Ultrasound	15.00	
IFC/ Micro	15.00	
Soft Tissue	17.00	

Therapy is not mandatory, but definitely recommended. Therapy helps you relax prior to your adjustment and helps heal the muscles, tissues and reduce inflammation.

Please plan approximately 40 minutes for a visit with therapy and approximately 20 minutes without therapy.

Injections		*Typically not covered by insurance*
Initial Office Visit	150.00	
Neural Prolotherapy	150.00	Series of 5-8 weekly injections
Prolozone	150.00	Series of 3-6 weekly injections
Trigger Point	98.00	
Dry Needling	98.00	Series of 3-5 weekly treatment

Medical Care	
Initial Office Visit	150.00
Follow-up Office Visit	110.00
Allergy Testing	240.00

Please plan approximately 40-60 minutes for all Medical and Injection visits.

Other Charges		*Not covered by insurance*
Missed Appointment Fee	45.00	
After Hours	110.00	
Emergency Care	110.00	
Phone Call	45.00	
Returned check	25.00	

Integrative Health & Wellness
Lewiston Family Chiropractic

Integrative Care

I am aware that Kurt A. Bailey is trained as a Doctor of Chiropractic and Naturopathic Medical Doctor and as a Family Nurse Practitioner. I can see him for any of these specialties, individually or collectively.

I understand I can ask for treatment from one of these professions and it is possible my care/ treatment may cross between chiropractic, naturopathic and medicine, and I may be asked to return for an additional appointment in order to complete further examination, lab work, x-rays, injections, etc.

I understand the cost of care will be based upon treatment rendered at the time of service.

__________________ Patient Initial

HIPAA Privacy Practice

In general, the HIPAA policy gives individuals the right to request a restriction on uses and disclosures of Protected Health Information (PHI). Our Policy is to take reasonable steps to limit the use or disclosures of PHI to the minimum necessary to accomplish the intended purpose. Your personal photo will be taken and used for identification and clarification purposes only. We also do not release PHI without your informed consent.

I acknowledge that a copy of the clinic's Notice of Privacy Practices is available to me. I further acknowledge and understand that if I have any questions about Dr. Bailey's privacy practices or my rights with regard to my personal health information, I may contact the clinic office for further information.

__________________ Patient Initial

Notice of Release of Records

I agree that the clinic may disclose certain portions of my health information to a family member, friend or other caregiver because such person is involved with my health care of payment relating to my health care. In that case, Dr. Bailey's office will disclose only information that is directly relevant to the person's involvement in my health care or payment relating to my care.

__________________ Patient Initial

Disclosure of Fee's / Payment Policy

I understand that I am responsible for payment of all services rendered. If I have insurance, the clinic may bill as a *courtesy only* and in the event my insurance fails to pay I am responsible for any remaining balance. I understand that if any balance remains unpaid for any extended period of time that I promise to pay any and all collection, court and attorney fees in association with the collection of my account.

__________________ Patient Initial