

**STEVEN WASSERMAN, R.N., D.C.**  
3772 KATELLA AVE., STE. 100  
LOS ALAMITOS CA 90720  
(562) 430-4949

### **PPO FINANCIAL POLICY**

Dear New Patient,

Please be advised that our financial policies take into account the requirements of the Insurance Companies, California Insurance Commission, and the ever-changing needs of this practice.

Our office makes no representation that your insurance policy will positively cover all or some of your Chiropractic care, therefore, we require that you the patient, be responsible for knowing your benefits and policy limits.

All insurance plans have policy limits. These may include dollar amounts, number of visit, and some services or supplies that may or may not be covered. We will inform you prior to rendering these services or supplies. These services that may not be included are: electrical stimulation, hot pack, ultrasound, laser, x-rays, and supplies.

**\*\*\*Please come prepared to pay your deductible, co-pay, and co-insurance at the time of service. Our office will calculate an estimated amount due, taking into account usual insurance payments. We accept cash, credit cards, and checks with credit card on file only. Any overpayment of deductible or co-insurance will be reimbursed directly to you.**

**Our charges for chiropractic services rendered are: 1) exactly within the medical fees of Southern California 2) according to each insurance company our office is contracted with, and 3) set by each insurance company according to their procedure code fees and copayment schedules or percentages due. All charges for services rendered vary depending on what procedure was done and according to the complexity of the problem. For example, we may bill your insurance company \$85.00, but our contract with that insurance company or the insurance company's own policy for chiropractic coverage only allows \$60.00 payment to the doctor for services rendered and allows our office to collect from the patient \$10.00 for the co-payment, percentage due, or coinsurance. The remaining \$15.00 is waived per insurance company's contract with our office. These breakdown of charges and payments are printed on your explanation of benefits that you will receive in the mail from your insurance company. **You, however, are ultimately responsible for your bill and if you exceed the policy limits, you will be responsible for payment in full for those visits.****

Your **initial consultation and exam** may vary from \$75 to \$300 and our average fees per **routine visits** will vary from \$45.00 to \$100.00. Again, depending on insurance plan coverage, what procedures were done; exam, adjustment, physical therapy modalities, and x-rays, fees will vary.

**OUR OFFICE DOES NOT BILL REMAINDER OF BALANCES DUE. ALL FINANCIAL MATTERS WILL BE HANDLED AT TIME OF SERVICES FOR DEDUCTIBLES, COPAYS, AND CO-INSURANCE.**

**DEDUCTIBLE:** Any deductible owed is payable in full (up to the total charge of the office visit) and is due at time of service. Most deductibles will vary from \$100-\$5000 per calendar year. Your estimated deductible portion first visit will be: \$150.00 with x-rays  
\$ 75.00 without x-rays

**COPAYMENTS OR PERCENTAGE DUE ARE COLLECTED PRIOR TO TREATMENTS,** cash or credit card only.

1. Must pay your contracted amount of co-payment or percentage due at time of service
2. Must pay for additional services that may not be covered by your policy, which we will inform you prior to rendering those services or supplies to you. These additional services that may not be covered are: hot pack, electrical stimulation, ultrasound, and/or muscle therapy.

**THREE PAYMENT OPTIONS ONLY:**

**1. CASH**

**2. PAYMENT WITH CHECKS:** If you choose to pay with a check, it is our office policy that a copy of your credit card be left on file. If a check bounces, your credit card will be automatically charged the amount of check plus a \$25.00 bounced check fee, no exceptions. We will send you notification that your credit card has been debited.

**3. VISA, MASTER, AND DISCOVER CARD.**

\*Please note this office does not bill remainder of balance due. All financial matters are handled at time of service. If payment is not received or other arrangements have not been made, your credit card will be charged within 5 working days of date of service.

I have read the above, and agree to the terms of this office's policy.

\_\_\_\_\_  
Signature

Date:\_\_\_\_\_

Printed name\_\_\_\_\_