172 E. State Street, Ste 502

Columbus, OH 43050

614-229-5290

Patient Prepayment Agreement

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This document represents an agreement between the above signed patient and **The Ohio State Chiropractic Association.** This agreement outlines a care plan created specifically for the patient based on the evaluation performed on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Duration of the Plan:**

\_\_\_\_\_ visits a week for \_\_\_\_\_ weeks(s) at the conclusion of these visits I will be re-evaluating the patient to monitor treatment effectiveness and modify the treatment plan as necessary at that time.

**Treatment Plan:**

During this time frame we would expect approximately 12 visits to be provided. This will vary based on how the patient responds to the care provided and will be monitored and evaluated at each re-evaluation.

Based on the initial evaluation we will be treating the patient for the following conditions:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Services, Goods, and Appliances Covered by the Agreement:**

Type of Treatment Cost of Treatment Number of Treatments Total

Chiropractic Adjustment $45 12 $540

Electrical Stimulation $25 6 $150

Manual Therapy $30 6 $180

Initial Evaluation $100 1 $100

Re-Evaluation $55 1 $55

X-Rays $75 3 $225

**Total Cost of Plan: $1,250**

**Separate or Distinct Fees for Services, Goods or Appliances NOT Covered by the Agreement:**

Type of Treatment Cost of Treatment

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment Arrangements:**

Your insurance covers on an 70/30 basis. This means that your insurance will cover 70 percent of your medical expense, and you are responsible for the remaining 30 percent. This works out as follows:

**Deductible:** $200.00

**Office Visit:** $104.00

**Insurance covers:** $73.00

**You’re responsible for:** $31.00

We are starting you out on a 12 visit care plan. If you choose:

To pay weekly, you would pay: 10 visits X $31.00 = $310.00 + $200 Deductible = $510.00 = **$127.50/WK**

To pay in full, you would pay: $510.00 X 15% Discount = $433.50 (Savings of $76.50)

\_\_\_ I choose to pay in full, which includes the savings amount for the 12 visits.

\_\_\_ I choose to pay weekly, which does not include the savings amount for the 12 visits.

**Disclaimers:**

In the event of a new diagnosis, new condition, or new injury (such as an auto accident or worker’s compensation claim), this plan may be put on hold, at the treating physicians discretion. The new diagnosis, condition, or injury may be treated until the patients status returns to the status immediately prior to the new diagnosis, condition or injury, as determined by the treating physician. This plan would then commence again, using the exact number of days remaining before the plan was put on hold.

If the patient should complete care early, or voluntarily discontinue care by providing a 14 day written notice to **The Ohio State Chiropractic Association,** then the total number of visits used to that point will be determined, and the full fee charged for each service provided. Any unused funds will be refunded to the patient within 14 days of such request by the patient. A statement showing accounting of all funds used within this plan is also available within 14 days of written request by the patient.

I have read and fully understand this agreement.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Witness Date