Time Of Service Discount

Popovich Chiropractic is pleased to offer **EVERYONE** a 15% time of service discount. A Time of Service Discount is a discount off of our standard fee schedule here at Popovich Chiropractic.This discount is available to any and all patients that need to make a payment at the time of service(such as for cash patients, and in-network insurance patients that opt into this plan). Payment can be made via cash, or credit card. There are many administrative costs and extra tasks that must be completed when processing insurance claims. A patient paying at the time of service greatly lessens this workload which allows us to pass a significant savings on to both the patient and their insurance company for those patients who submit their own claims to the insurance company for reimbursement. You can be sure our prices are always fair as we use the latest recommended prices from Medicare's Physician Fee Schedule for Western Pennsylvania. Please see the chart below for examples of our standard fee and TOS discount fee on some of our most common services.

CPT	Description	Standard Fee	TOS Discount
99203	new patient exam level III	$105	$89
99213	established patient exam level III	$71	$60
98941	chiropractic adjustment 3-4 regions	$45	$38
98942	chiropractic adjustment 5 regions	$52	$44
97110	physical therapy	$31	$26
97012	traction	$16	$14
97014	electrical stimulation	$13	$11

99202	new patient exam II	$72	$61
99212	established patient II	$42	$36
97140	manual therapy	$29	$25

Feel free to privately discuss any financial concerns or difficulties you may have regarding your account. Early and open communication in these situations affords everyone the opportunity to reach a resolution suitable to all parties.

By signing below, I agree to the following: "I have read, understand, and agree with the preceding described financial policies. By signing I agree that I also understand that as the patient or legal guardian of the patient, I am ultimately personally responsible for any and all costs associated with the course of my treatment and care at Popovich Chiropractic.

Failure to pay all costs associated with my care as agreed may result in collection activity on my account as well as reporting of my payment history to credit reporting bureaus."

Patient Name: _____ X_____

(SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE)

(Please Print)