WESTCOTT CHIROPRACTIC CENTER

29671 Six Mile Road
Suite 110C
Livonia, MI 48152
(734) 427-1579

Dr. Jennifer L. Westcott

"Your Spine Is The Key To Good Health"

EXPLANATION OF CHARGES FOR SERVICES RENDERED

We have many options depending on your insurance or lack of insurance. Below you will find our fees for services rendered. We will try to help you in any way in order to serve you better. Keep in mind we are providing you with the most updated technology and advances in health care, and ask that you pay when services are rendered.

Service	Fee
X-RAYS	
Cervicals (2 views)	$ 60.00
Lumbo / Pelvic (2 views)	$ 70.00
OFFICE VISIT / ADJUSTMENT	$ 50.00
CONSULTATION / INITIAL EXAM	$130.00
PREPAY 10 VISIT PLAN (not billed to insurance)	$400.00
LASER THERAPY 1 TREATMENT (not payable by insurance)	$ 30.00
LASER THERAPY 10 VISIT PREPAY (not payable by insurance)	$200.00
ADJUSTMENT W/LASER THERAPY (not billed to insurance)	$ 65.00
NUTRITIONAL COUNSELING (not payable by insurance)	$ 50.00
KINESIO-TAPING (not payable by insurance)	$5.00-$20.00

Expect on your first visit as a new patient that you or your insurance will be charged for x-rays that are taken and an initial consultation/exam. After your first visit, the charges are just for an adjustment unless you choose to have other therapies. (Some services are **not payable by insurance**. You will be responsible for charges)

ASSIGNMENT AND RELEASE

I, the undersigned, recognize that I have no insurance and am responsible for the charges that are incurred for treatment received at Westcott Chiropractic Center.

Signature of Patient (Parent or Guardian) ______________________________ Date ______________________

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with ____

and assign directly to Dr. Jennifer L. Westcott all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not by insurance. I hereby authorize the doctor to release all of the information necessary to secure the payments of benefits. I authorize the use of this signature on all of my insurance submissions whether manual or electronic.

Signature of Insured (Parent or Guardian) ______________________________ Date ______________________

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MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf, to Dr. Jennifer L. Westcott for any services furnished to me by the physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits of the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, Dr. Jennifer L. Westcott does not agree to accept the charge for the deductible, coinsurance and non-covered services.

Signature of Beneficiary ____ Date ____________________