



Dr. Nate Greenstein

**Fees, Financial and Insurance Information
(Medicare Patient)**

Two factors determine your charges for any particular visit. They are: (1) the type of service rendered and (2) the amount of time spent to perform the service.

The fee for an initial physical examination and subsequent evaluations can range from \$100.00 to \$300.00. The typical cost is \$200.00.

The cost for spinal manipulation can vary from \$27.00 to \$50.00 per visit.

We offer Avicenna high power laser therapy. It's the most powerful therapeutic laser in the United States. Laser therapy is billed at \$6.00 per minute. Treatment time can vary with each area treated, and is usually between 15 to 30 minutes per area.

The cost for other physical therapies range from \$40.00 to \$50.00 per procedure. The typical cost is \$45.00 per procedure.

Other services and products include: X-rays; laboratory & bone density testing; diet & nutritional counseling; nutritional supplementation & orthopedic supports.

Payment is expected at the time the service is rendered. We accept cash, check, MasterCard, Visa, Discover Card and the American Express Card.

After your deductible has been met, you may or may not have coverage through Medicare. If you have a musculoskeletal condition and that condition is directly related to the spine, your treatment will probably be covered. Medicare will pay for spinal manipulation at approximately 80%. A supplemental insurance policy will pay for spinal manipulation at approximately 20%.

This office does not accept assignment on Medicare benefits. You are responsible for payment of all services rendered. We will prepare and send your claim to Medicare for you to receive payment.

Medicare will not reimburse you for an initial physical examination or for subsequent physical evaluations, diagnostic testing, physical therapy, diet & nutritional counseling, nutritional supplementation and orthopedic supports.

If Medicare denies payment for any of the spinal manipulations, I, as the beneficiary, authorize you, Dr. Greenstein, to act on my behalf to request a review.

Twenty-four hour notice to cancel or reschedule an appointment is required or we reserve the right to charge for the visit.

If you have any questions, please do not hesitate to ask us.

Patient Signature: _____ Date: _____

Patient Printed Name: _____