Provider Fee Schedule Worksheet

If you currently offer cash or time of service discounts, you may consider keeping your discounts in the same range when setting your ChiroHealthUSA fee schedule. Using ChiroHealthUSA will allow you to continue offering discounts within a legal network model.

Section 1 *REQUIRED* – Fee Schedule

Under the terms of this agreement, all providers must offer a minimum of a 5% discount on professional services. You may choose to offer discounts that are more significant to patients. While we do not dictate the discounts you offer, many discount medical plans offer discounts in the range of 10% to 30% and even up to 50% on some services. Below, you will enter the percent discounts you wish to offer; for example 20%. Most providers additionally choose to set a "capped" or maximum fee for new patient visits and/or routine office visits; for example, you may charge a $125.00 maximum for an all-inclusive first visit and/or $45 for an all-inclusive routine visit. ***These options are not required. If you choose to do so, enter your selections below.***

For All Member Patients

Members of ChiroHealthUSA will be offered a
5% ☐ discount off professional services.
10% ☐ discount off professional services.
20% ☐ discount off professional services.
30% ☐ discount off professional services.
Other:____ discount off professional services.

Section 2 *OPTIONAL* – Fee Schedule

A. New Patient Services On Same Day
Limited to Maximum Fee of:
☐ $ 75.00 for all non-covered services.
☐ $ 125.00 for all non-covered services.
☐ $ 150.00 for all non-covered services.
☐ $ 175.00 for all non-covered services.
☐ Other: $ _____

B. Routine Office Visits: *(defined as CMT & therapy)*
Limited to a maximum fee of:
☐ $35.00 for all non-covered services.
☐ $45.00 for all non-covered services.
☐ $55.00 for all non-covered services.
☐ $75.00 for all non-covered services..
☐ $Other: _____ for all non-covered services.

C. For Medicare or other *partially insured* patients and when services <u>other</u> than a routine office visit as noted in "2B" are rendered, you may select a flat fee per CPT code for their non-covered services.

If you would like to set certain discounted fees per code, fill in this section.
$____ for CMT codes (989x series)
$____ per modality (970xx series)
$____ per procedure (971xxseries)
$____ per service (975xx series)
$____ per service (977xx series)
$____ per EM code (9921x series)
$____ per film (720xx series)
$____ per other service, please list (97810: Acupuncture)
(Use additional pages if needed)

Section 3 *OPTIONAL* – Materials, Supplies, Orthotics, Nutritional

The percentage discount you selected above was for professional services only. If you choose to offer discounts on supplies and materials, please enter the percent discount here.
_____% off on durable medical goods.
(TENS, Equipment, Rehab Materials etc.)
_____% off stock orthotics, pillows, supports, soft goods etc.
_____% off CUSTOM orthotics supports soft goods etc.
_____% off Nutritional supplements or products

Section 4 *OPTIONAL* – Exclusions

(Use separate page if necessary)
Providers who utilize specialty services: decompression, acupuncture, laser etc. are encouraged to extend discounts but may exclude these services listed below, if any (include CPT code & Description).

_____
_____

Section 5 *OPTIONAL* – Family Plan Addendum

The first member of a family should be extended the discounts selected in Section 1(above). For additional family members, you may offer the discounts selected in Section 1or you may choose to offer more substantial discounts noted below. You may also choose to offer a "capped" or maximum, per visit fee for each subsequent family member. If you do not wish to set a capped or maximum fee, please leave the "maximum fee" line blank.

Family Members Discounts are:

First Visit

1st member discounts are as noted above in Section 1/Section 2

2nd or Subsequent Patient Family Member
____% discount, or a maximum fee of $_____ for all non-covered services on their first visit.

3rd or Subsequent Patient Family Member
____% discount, or a maximum fee of $_____ for all non-covered services on their first visit.

Routine Office Visits

1st member discounts are as noted above in Section 1/Section 2

2nd or Subsequent Patient Family Member
____% discount, or a maximum fee of $_____ for all non-covered services on routine office visits.

3rd or Subsequent Patient Family Member
____% discount, or a maximum fee of $_____ for all non-covered services on routine office visits.

ROUTINE OFFICE VISIT STIPULATION

To receive family plan discounts on routine office visits family members must be seen:

☐ On the Same Day

☐ In the Same Week

☐ No stipulations

_____ Other stipulations:

_____

_____

_____

SIGN HERE

_____

Provider or Clinic Owner Signature Required

Date_____

Based on your choices above, we will supply you with a "fee schedule" that will allow your staff to review the discounts offered in your clinic. Below is a sample.