

Our Fee Structure

Please note our fees for your initial visit:

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|---------------------|--|
| Consultation | Complimentary |
| Examination | \$ 150.00 |
| Radiology | Variable (performed outside of office) |
| TOTAL | \$ 150.00 |

Please note that if you have been involved in a motor vehicle accident, our fee structure may differ due to the complexity of your needs in such cases.

Please also note that your clinical Report of Findings, the time that your doctor will spend with you to go over your results, will be \$ 20.00.

I fully understand the above fees and give my consent. I also give my consent to have the doctor take any x-rays he/she deems appropriate to better understand my problem and monitor my progress.

SIGNATURE: _____ DATE: _____
(Signature of Parent/Guardian required if patient under age 18)

Thank You!