

Expanding Our Inner Space



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FEE SCHEDULE

Structural Integration - \$97 per session (normally taking 90 minutes.)
 Massage Therapy - \$70 per hr., \$90 per full body session (90 minutes.)

These rates are broken down per Insurance CPT codes as follows:

CPT Code	Description	Fee Schedule *
99202 or 97001	New Client – 1 st Office Visit Limited (15-30 min.)	\$ 42
99212	Follow-up Office Exams	\$ 23
97124	Massage, including effleurage (each 15 min. unit)	\$ 25
97139 or 97140	Structural Integration (each 15 min. unit)	\$ 25

* Add \$5.00 for Visa or MC credit card processing

1. PAYMENT POLICIES:

Payment is expected via cash, personal check, or credit (Visa or Master Card) at the time services are provided under any discounts. A valid credit card number on file may be required to guarantee payment.

Insurance Billing: With my assistance, you will be responsible for billing your insurance company except for companies where I have approved my listing as a preferred provider. This includes insurance billing for private health, personal injury, and/or workman's compensation.

All accounts not paid in full within 90 days from date of service will be charged interest. Interest rates are 12% annually and are charged at 1% monthly. Interest is calculated on the principal amount; interest is not compounded.

2. OFFICE POLICIES

Cancellations: Cancellations or rescheduling must be made 24 hours in advance of the scheduled appointment time. Payment in full is required for the full time originally scheduled, if cancellation or rescheduling is done in less than 24 hours, or if a full session cannot be given due to tardiness. This charge will be waived if a replacement can be found for your appointment time. Your insurance company will not be charged for your missed appointment; you will be responsible for payment out-of-pocket. Emergency cancellations will receive special consideration.

The following credit card guarantees payment if necessary: Type: _____ (Visa or MC only please)

Number: _____; Expiration: _____; Security: _____; Billing Zip: _____;

Right of Refusal: I reserve the right to refuse service to anyone. This includes but is not limited to anyone who requests treatment or services that are outside my scope of practice. I will exercise this right if anyone arrives for treatment under the influence of alcohol or recreational drugs; I reserve the right to charge for the session time, whether or not services were rendered.

I have read the policies stated above and agree to abide by them.

Client Signature: _____ Date: _____