JOINTFIT
CHIROPRACTIC & SPORTS MEDICINE CENTER

Schedule of Fees
As of 4/22/2021

Code	Description	Amount	Type of Charge
29280	Taping/ Bracing Hand	$10.00	Service
29540	Taping/Bracing Foot/Ankle/Leg	$10.00	Service
97012	Mechanical Traction for Neck or Back	$20.00	Service
97014	Electrical Stimulation of Muscle. Soft Tissue	$20.00	Service
97035	Therapeutic Ultrasound	$20.00	Service
97110	Therapeutic Exercise (Acute P.T. care)	$35.00	Service
97112	Neuro-muscular Re-education Training	$35.00	Service
97116	Gait Training	$35.00	Service
97140	Manual Therapies (Trigger point work, mobilization, myofascial release)	$40.00	Service
97530	Therapeutic Activities (Advanced dynamic P.T. to improve function	$35.00	Service
97750	Physical Performance Test with Written Report	$35.00	Service
98940	Spinal Manipulation (Adjustment) 1-2 Regions	$45.00	Service
98941	Spinal Manipulation (Adjustment) 3-4 Regions	$60.00	Service
98942	Spinal Manipulation (Adjustment) 5 Regions	$60.00	Service
98943	Extremity Manipulation (adjustment)	$40.00	Service
99201	New Patient Focused Exam	$45.00	Service
99202	New Patient Expanded Problem Focused Exam	$90.00	Service
99203	New Patient Detailed Exam	$120.00	Service
99204	New Patient Comprehensive Exam/ Moderate Complexity	$135.00	Service
99205	New Patient Comprehensive Exam/ High Complexity	$150.00	Service
99211	Existing Patient Minimal Exam	$30.00	Service
99212	Existing Patient Problem Focused Exam	$50.00	Service
99213	Existing Patient Expanded Exam	$60.00	Service
99214	Existing Patient Detailed Exam	$90.00	Service
99215	Existing Patient Comprehensive Exam	$115.00	Service
96116	Neurobehavioral Status Exam “Concussion Testing”	$120.00	Service
99385	DOT Exam (Initial Comprehensive Medical Exam-Adult)	$85.00	Service/Patient
76881	Diagnostic Ultrasound Joint/Extremity/Soft Issue (Full Exam)	$230.00	Service
76882	Diagnostic Ultrasound Joint/Extremity/Soft Issue (Limited)	$60.00	Service
	Half Foam Roll	$20.00	Patient
	Full Foam Roll	$20.00	Patient
	Cervical Denneroll	$50.00	Patient
	Aline Insole and Fitting	$100.00	Patient
	Biofreeze	$12.00	Patient

I acknowledge that I have read and understand the fee schedule of JointFit, Pa., that fees are based upon services performed, and that total visit fees may vary. I am responsible for payment for services that I receive or those that insurance may not fully cover. I understand that payment arrangements may be possible and I should inform JointFit of financial difficulty prior to receiving services.

Print Name: _____ Signature:_____ Date: _____