

THE INSURANCE OBJECTION PLAYBOOK

Word-for-word scripts, a chiropractic superbill template, a patient handout and payment options for every "Do you take my insurance?" call.

For cash and out-of-network chiropractic practices. Last reviewed September 2026.

By Nick Fischer, founder of CHIROBASIX

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WHY THIS OBJECTION COSTS YOU MORE THAN YOU THINK

Before you change a single script, look at what the insurance call is actually costing you.

The insurance objection is when a caller asks “Do you take my insurance?” and pulls back when the answer is no. In a cash or out-of-network practice, it's usually a cost question in disguise. Answer it honestly, with real options like superbills, HSA and FSA cards and financing, and the call keeps going.

Here's the kind of email that started this guide. A cash-practice client told us many of their Google callers only want to use insurance. When the front desk mentions the New Patient Special, callers say some version of “Thank you, but I'd rather go some place I can use my insurance.” Then they hang up.

When we dug into the account, we saw two other things: a seasonal dip, and leads that weren't getting a second call. The insurance objection was real, but it wasn't the whole story. That's worth knowing before you blame the insurance question for a slow month. The objection gets the blame because it's the thing people say out loud.

Every one of those calls is a lead you already paid for, with ad spend, SEO work or years of reputation. When the front desk hears “insurance” and answers “No, but we have a New Patient Special,” it has answered a question the caller didn't ask. The caller wanted to know what this will cost, whether it's worth it, and whether the money they spend on insurance can help. A flat no answers none of that.

THE DEDUCTIBLE MATH YOUR CALLERS HAVEN'T DONE

KFF's 2025 Employer Health Benefits Survey found that 88% of workers with single employer coverage have a general annual deductible, and among them the average is \$1,886. About a third of covered workers (34%) have a single-coverage deductible of \$2,000 or more. HealthCare.gov defines the deductible as what you pay for covered services before your plan starts to pay, and KFF says it applies before most services are paid. Some plans charge a flat copay for office visits instead. So a caller who says “I want to use my insurance” may be paying the plan's rate out of pocket until the deductible is met, or may have a low copay. Either way, it's a reason to help them compare real numbers, not to knock their plan.

What you'll walk away with

- Word-for-word phone, text, email and in-office scripts that answer the insurance question honestly and keep the conversation going.
- A chiropractic superbill template and field checklist built from what Cigna, UnitedHealthcare and Aetna ask for.
- A print-ready patient handout and step-by-step SOP for submitting a superbill, plus the questions to ask the insurer.
- The Medicare, Medicaid, auto and work-injury exceptions, in plain language. This is where cash practices get in trouble.
- A payment options menu: Cherry financing, HSA and FSA, short payment plans and packages, with the cautions that come with each.
- A follow-up system, a slow-season playbook, a weekly tracking sheet and a 7-day action plan.

READ THIS FIRST

This guide is general education for practice owners, not legal, billing or tax advice. Insurance, Medicare, Medicaid and advertising rules vary by state and by plan. Before you change your pricing, packages, memberships, financing offers or ads, confirm your approach with your state chiropractic board, a healthcare attorney or a certified billing and coding specialist. Anything labeled "Florida example" applies to Florida only. Facts were checked in September 2026, and rules change, so re-check anything before you act on it.

WHAT THE CALLER IS REALLY ASKING

"Do you take my insurance?" is rarely just about insurance. Here's how to hear what's underneath it.

Most of the time the caller is really asking: What will this cost me, and is it worth it? Sometimes it's something else: habit, trust, a spouse who handles the money, or a bad experience with a surprise bill. Either way, your team answers the insurance question first, with the fix in the same breath, then sorts the caller before quoting a price or offering times. If the caller still hesitates, that's when they find out which one it is.

Translate the objection

What they say	What it often means	Your move
"Do you take my insurance?"	"How much will this cost me?"	Answer it with the fix in the same breath, then ask what's going on and sort the caller.
"I'd rather go where I can use my insurance."	"I pay for insurance. I want it to help."	Offer the superbill like it's routine and save the details for the visit. Give two times. Still no? Offer to hold one, once.
"Can you just bill my insurance?"	"I don't want paperwork or surprises."	Explain the superbill in one breath, make it sound easy, then offer two times. Offer questions to ask their plan only if they want to check first.
"My insurance covers a chiropractor across town."	"Why would I pay more?"	Give the superbill answer, the price and two times. Still no? Offer a hold once and leave the door open.
"I need to think about it."	Cost, schedule, insurance or a spouse.	Ask which one, answer it in a line, and offer an easy-to-move hold. Spouse? Send the details and set a check-back time.
"I'm on Medicare."	Different rules apply.	Hand off to your trained Medicare person. No cash quotes.

WHY PLAN TYPE CHANGES THE ANSWER

HealthCare.gov says an HMO “generally won't cover out-of-network care except in an emergency,” an EPO covers services only in network (except emergencies), and a PPO lets members see out-of-network providers “for an additional cost.” KFF's 2025 survey found PPOs cover 46% of covered workers and HMOs 12%. So some callers have out-of-network benefits and some almost certainly don't. Nobody in your office can know what a plan will pay, but asking the plan type tells your team which path to offer.

One more thing that trips up practices and patients: out-of-network reimbursement is figured from the plan's allowed amount, not from your fee. HealthCare.gov defines the allowed amount as “the maximum amount a plan will pay for a covered health care service.” That's exactly why nobody on your team should ever promise a patient what they'll get back.

Sort every caller before you quote a price or offer times

1. PPO or POS plan through work or on their own, or not sure of the plan type: the superbill answer, then two times (Parts 5 and 6).
2. HMO or EPO: skip the superbill. These plans usually don't cover out-of-network care, so the caller pays you directly by card, HSA or FSA card, or a Cherry payment plan if they qualify. Then two times.
3. Medicare, including Medicare Advantage: hand off to a trained person. No cash price, no ballpark, no superbill (Part 7).
4. Medicaid: ask them to call their plan first, and offer to hold a time while they check. Coverage depends on the state and the plan.
5. Car accident or work injury: a separate intake process. Those claims follow their own rules.
6. No insurance, or insured but not using it: your cash price plus a written Good Faith Estimate.

Then teach your team one simple framework for any objection. It's adapted from Carew's LAER model (Listen, Acknowledge, Explore, Respond).

The 4 A's

- Acknowledge. Three words or fewer, like “Got it” or “Sure,” or skip it and go straight to the answer. Don't say their concern back to them or give a sympathy speech.
- Answer. Give the fix in the same breath so “we're out of network” never hangs: “We're out of network, so what we do is give you a superbill.” Make it sound routine (“We do this all the time”), tie any payback to “depending on your plan” and save the details for the visit.
- Ask. Find out what's going on and sort the caller: plan type, Medicare or Medicaid, an injury. If they hesitate, find the one thing holding them back (cost, schedule or the insurance part) and answer it in a line.

- Advance. Offer two specific times, then stop talking. Still unsure? Offer to hold a time that's easy to move. Once.

HOUSE RULES FOR THE PHONE

Jump on the insurance question and fix it in the same breath: "We're out of network, so what we do is give you a superbill." Say it like it's routine: "We do this all the time." Tie any payback to "depending on your plan" and save the details for the visit. Then ask what's going on and sort the caller before you give a price or offer times. The superbill answer fits a PPO or POS plan, or a caller who isn't sure. Medicare, Medicaid, HMO, EPO and injury callers get their own script: if they tell you up front, skip the superbill, and if the sort turns it up, switch to that script. Medicare callers never get a price. Once the caller is sorted, offer two times and stop talking. No "unfortunately," no sympathy speeches, no homework before the booking.

THE PHONE SCRIPTS

Print these. Rehearse them out loud. Swap in your own details wherever you see brackets. Every script answers the insurance question honestly and never promises reimbursement.

The first 30 seconds

Sort before you offer times. Medicare, Medicaid and injury callers go to their own script. If the caller wants to use their insurance, ask the plan type too (the sorting question below).

FRONT DESK Thanks for calling [Practice], this is [Your name]. Who am I speaking with?

CALLER Hi, this is [Caller].

FRONT DESK Hi [Caller]. What's going on that has you calling us today?

CALLER [Describes the problem. Let them talk. Don't interrupt.]

FRONT DESK How long has that been going on?

CALLER [Answers.]

FRONT DESK What's it keeping you from doing right now?

CALLER [Answers.]

FRONT DESK Got it. Did anything set it off, like a car accident or something at work?

CALLER [Answers.]

FRONT DESK And real quick, are you on any kind of Medicare or Medicaid plan?

CALLER [Answers.]

FRONT DESK Okay, let's get you in. The doctor will look at exactly that on your first visit and tell you what they find. I've got [day] at [time] or [day] at [time]. Which is better?

When insurance is the very first question

The pattern for every insurance question: answer it, give the fix in the same breath, make it sound normal, save the details for the visit, then offer two times and stop talking. Before you offer times, ask the sorting questions. If it's Medicare (including Medicare Advantage), Medicaid, an HMO or EPO, or an injury, take the superbill back in one line and switch to that script below. For Medicare:

"Okay, with Medicare the superbill part doesn't apply. [Team member] handles all our Medicare calls."

CALLER Hi, do you take Blue Cross?

FRONT DESK We're out of network with Blue Cross and don't bill insurance directly, so what we do is give you a superbill. It's a detailed receipt you send in to Blue Cross, and depending on your plan, they may count it toward your out-of-network deductible or pay you back for part of it. We do this all the time. It's easy, and you know your cost up front.

CALLER Oh. Okay.

FRONT DESK When you come in, we'll break it all down for you and give you the instructions for sending it in. That's how a lot of our patients handle it. What's going on that has you calling?

CALLER [Describes the problem.]

FRONT DESK Got it. Is your Blue Cross through work or on your own, or is it a Medicare or Medicaid plan?

CALLER Through my work.

FRONT DESK Do you know if it's a PPO, HMO or EPO? It's usually on your card.

CALLER PPO, I think.

FRONT DESK And did this just come on, or was it from a car accident or something at work?

CALLER It just came on.

FRONT DESK Okay, let's get you in. Your first visit is [\$97], and you'll get the cost in writing too. I've got [day] at [time] or [day] at [time]. Which is better?

Who is calling? (the sorting question)

When insurance comes up, ask this before you quote a price or offer times. A PPO or POS plan through work or on their own, or a caller who isn't sure, gets the superbill answer if they haven't heard it yet, then two times. HMO or EPO, Medicare (including Medicare Advantage), Medicaid, a car accident or a work injury: switch to the matching script below, even if you already mentioned the superbill. No insurance: the price and a Good Faith Estimate. If insurance never comes up, the shorter check in "How much is it?" is enough.

FRONT DESK Real quick, do you have insurance through work or on your own, or is it some kind of Medicare or Medicaid plan?

CALLER [Answers.]

FRONT DESK Do you know if it's a PPO, HMO or EPO? It's usually on your card.

CALLER [Answers.]

FRONT DESK And did this just come on, or was it from a car accident or something at work?

CALLER [Answers.]

FRONT DESK Okay, got it.

“How much is it?”

Sort before the number. Medicare callers never get a cash quote, and Medicaid and injury callers go to their own script too. If the caller doesn't book, still ask before you hang up: “What's the best email for your Good Faith Estimate?” A cost question counts as a request, so it's due within 3 business days even without a booking.

CALLER How much is it?

FRONT DESK Real quick, is this from a car accident or a work injury, or are you on any kind of Medicare or Medicaid plan?

CALLER No, none of those.

FRONT DESK Okay. Your first visit is [\$97]. That includes [consultation, exam, and an adjustment if the doctor says it's appropriate]. You'll get the cost in writing too.

CALLER Okay. And after that?

FRONT DESK That depends on what the doctor finds, and they'll go over it with you, cost included, before you start anything. What's going on that has you calling?

CALLER [Describes the problem.]

FRONT DESK Okay, let's get you in. I've got [day] at [time] or [day] at [time]. Which is better?

CALLER [Picks a time.]

FRONT DESK You're all set for [day] at [time]. I'll email you a Good Faith Estimate with that cost on it. What's the best email for that?

CALLER [Gives email.]

STAFF NOTE: THE GOOD FAITH ESTIMATE

Under the federal No Surprises Act, any question or discussion about cost counts as a request for a Good Faith Estimate (GFE). The rule covers uninsured patients and insured patients who aren't asking you to bill their plan. A requested GFE is due within 3 business days. If a visit is booked 3 to 9 business days out, send it within 1 business day of scheduling. If it's 10 or more business days out, send it within 3 business days. The easy habit: send one to every cash patient.

"I'd rather go where I can use my insurance"

Ask the sorting question first if you haven't yet. This script is for a PPO or POS plan, or a caller who isn't sure. HMO or EPO, Medicare (including Medicare Advantage), Medicaid, a car accident or a work injury: switch to the matching script below, with no superbill pitch. Medicare callers never get a price.

CALLER Thank you, but I'd rather go somewhere I can use my insurance. It's a PPO through work.

FRONT DESK A lot of our patients have insurance too, so what we do is give you a superbill. It's a detailed receipt you send in to your insurance, and depending on your plan, they may count it toward your out-of-network deductible or pay you back for part of it. We do this all the time.

CALLER But I'd still pay more out of pocket, right?

FRONT DESK Depends on your plan, and we'll break it all down for you when you come in. The first visit is [\$97], and you'll get the cost in writing too. I've got [day] at [time] or [day] at [time]. Which is better?

CALLER I think I'll still go with someone in network.

FRONT DESK Want me to hold [day] at [time] while you check your benefits? Easy to move.

CALLER No, that's okay.

FRONT DESK No problem. Okay if I text you our info and a few questions to ask your insurance, in case anything changes?

EVERY NO GETS A NEXT STEP

Get a clear yes before sending any text. Then tag the contact insurance-objection in your CRM (ENGAGE, for CHIROBASIX clients) and start the follow-up sequence in Part 10. A caller who says no today is still a lead.

“My insurance covers chiropractic somewhere else”

Sort before the price and the times (the sorting question above). A caller whose plan covers a chiropractor in network may be on an HMO or Medicare Advantage. For an HMO, EPO, Medicare (including Medicare Advantage) or Medicaid caller, or a car accident or work injury, use the matching script below. HMO and EPO plans usually don't cover out-of-network care.

CALLER My insurance covers a chiropractor down the road.

FRONT DESK Got it. We're out of network, so what we do is give you a superbill to send in, and depending on your plan, they may count it toward your out-of-network deductible or pay you back for part of it. We do this all the time.

CALLER Okay.

FRONT DESK Your first visit is [\$97], and you'll get the cost in writing too. I've got [day] at [time] or [day] at [time]. Which is better?

CALLER I'll probably just go there.

FRONT DESK Okay. Want me to hold [day] at [time] while you look into it? Easy to move.

CALLER No, that's okay.

FRONT DESK No problem. Can I text you our info so you have it handy?

“Can you just bill my insurance?”

If you haven't sorted the caller yet, ask the sorting question above before you offer times. If they have Medicare (including Medicare Advantage), Medicaid, an HMO or an EPO, drop the superbill and switch to that script. HMO and EPO plans usually don't cover out-of-network care except emergencies, and a superbill is never a Medicare workaround. Only offer the questions to ask their insurance if the caller says they want to check first.

CALLER Can you just bill my insurance?

FRONT DESK We're out of network and don't bill insurance directly, so what we do is give you a superbill. It's a detailed receipt you send in to your insurance, and depending on your plan, they may count it toward your out-of-network deductible or pay you back for part of it. We do this all the time.

CALLER So I have to send it in myself?

FRONT DESK Yep, and it's easy. When you come in, we'll give you the instructions for sending it in. I've got [day] at [time] or [day] at [time]. Which is better?

CALLER	I'd kind of like to check with my insurance first.
FRONT DESK	Sure. Want me to hold [day] at [time] while you check? Easy to move.
CALLER	Yeah, okay.
FRONT DESK	You're penciled in for [day] at [time]. Your first visit is [\$97], and you'll get the cost in writing too. Want me to text you exactly what to ask them?
CALLER	Sure.
FRONT DESK	Sending it now.

HMO or EPO caller

Sort before the price. A lot of Medicare Advantage and Medicaid plans are HMOs too, so if the caller hasn't said, ask "Is that through work or on your own, or a Medicare or Medicaid plan?" Medicare and Medicaid callers go to their own script, with no price. For an EPO, say "EPOs" instead of "HMOs."

CALLER	I have an HMO.
FRONT DESK	Okay. HMOs usually don't cover out-of-network care, so you'd just pay us directly. We take cards and HSA and FSA cards, and we offer payment plans through Cherry.
CALLER	What's Cherry?
FRONT DESK	It's a payment plan company we work with. Checking if you qualify won't affect your credit score, and some plans are 0% if you're approved and pay on time. Other plans can carry interest. Want me to text you the link?
CALLER	Sure.
FRONT DESK	Sending it now. Your first visit is [\$97], and you'll get the cost in writing too. I've got [day] at [time] or [day] at [time]. Which is better?

"I need to think about it" or "I need to talk to my spouse"

Sort before the number. A Medicare caller (including Medicare Advantage) never gets a price, so switch to the Medicare script. Medicaid and injury callers go to their own script too.

CALLER	I need to think about it.
FRONT DESK	Sure. Is it more the cost, the schedule, or the insurance part?
CALLER	The cost, mostly.

FRONT DESK The first visit is [\$97], and you'll get that in writing. Nothing past that gets decided until the doctor goes over it with you, cost included. Want me to hold [day] at [time] while you think it over? Easy to move.

CALLER I really need to talk to my spouse first.

FRONT DESK Of course. Want me to text or email you the details so you can go over them together?

CALLER Text is fine.

FRONT DESK Sending it now. When's a good time for me to check back, tomorrow afternoon or [day]?

CLOSE THE LOOP

Whatever time the caller picks, log it as a follow-up task in your CRM before you hang up. The promise to call back is only worth something if somebody actually calls.

Medicare caller

If [Team member] isn't free: "Let me have them call you back today. What's the best number?" Then log the callback in your CRM.

FRONT DESK Are you on Medicare?

CALLER Yes, I am.

FRONT DESK Okay. Medicare has its own rules for chiropractic, so [Team member] handles all our Medicare and Medicare Advantage calls. They'll walk you through how it works.

CALLER Can you just give me a ballpark on the cost?

FRONT DESK Not with Medicare, no. [Team member] goes over all of that. Let me connect you now.

Medicaid caller

CALLER I have Medicaid.

FRONT DESK Okay. With Medicaid, the first step is a quick call to the number on your card to see if chiropractic's covered. Want me to hold [day] at [time] while you check? Easy to move.

CALLER Sure.

FRONT DESK You're penciled in for [day] at [time]. What's the best number for me to check back with you tomorrow once you know?

CALLER [Gives number.]

Car accident or work injury

FRONT DESK Were you hurt in a car accident or at work?

CALLER It was a car accident last week.

FRONT DESK Got it. Accident claims have their own rules, and [Team member] handles all of those for us. What date was the accident?

CALLER [Gives the date.]

FRONT DESK Okay. I'm connecting you with [Team member] now, and they'll get everything set up with you.

FLORIDA EXAMPLE: AUTO ACCIDENTS

Florida PIP pays medical benefits only if initial care is received within 14 days of the accident, and chiropractic physicians can provide that care. Route these callers straight to your office's PIP policy or referral answer. Auto claims are a different conversation from the insurance objection.

MAKE THE SCRIPTS YOURS

Only say what's true in your office. If you don't offer something (Cherry, HSA and FSA cards, courtesy claim filing, a particular price), cut that line. Before anyone says you take HSA and FSA cards, have your card processor confirm your practice is coded 8041 (see Part 8). Say "We do this all the time," "A lot of our patients have insurance too" or "That's how a lot of our patients handle it" only if it's true for your practice. Keep the pattern: answer with the fix in the same breath, save the details for the visit, sort the plan, then offer two times.

Never say this

- "No, we don't take insurance." (then silence)

- "It depends on your insurance," as your whole answer. It sounds evasive. Say what it depends on and when they'll get the details: "Depends on your plan, and we'll break it all down for you when you come in." Then offer two times.
- "Your insurance will pay you back" or "It should cover most of it." That's a reimbursement promise. Tie any payback to "depending on your plan" and keep it to "part of it," the way the scripts do.
- "We'll waive your copay or deductible" or "We'll code it so insurance pays." The OIG and Florida law treat these as fraud risks.
- "Insurance companies are a scam." It insults the caller's choice.
- "You'll only need X visits" or "You'll get better faster here." Those are outcome claims.
- "Everyone gets approved" or "It's 0% interest." Cherry says eligibility isn't guaranteed, and 0% APR depends on approval and on-time payments.
- To a Medicare caller: "Medicare doesn't cover us, so just pay cash."
- Any symptoms or diagnosis in a voicemail or text.
- "The special is only good today." Fake urgency.

IN THE OFFICE: WHAT THE DOCTOR SAYS

The doctor leads the clinical conversation. The team handles money from a written policy. Keep those lanes separate.

An article published on the California Chiropractic Association's website in May 2026, written by Dr. Ray Foxworth of ChiroHealthUSA (a discount medical plan company), argues that doctors should lead the clinical conversation and stay out of fee negotiation, with staff working from a written financial policy and a menu of pre-approved options. We agree with the principle: every patient hears the same terms, and the doctor's time goes to findings and recommendations, not haggling.

The doctor at the first visit

DOCTOR	Here's how today works. I'll examine you, then tell you honestly what I find and whether I think I can help. If I can't, I'll tell you and point you to someone who can. Nothing extra happens today unless you say yes.
PATIENT	Okay, sounds good.
DOCTOR	Here's what I recommend: [visit frequency, number of visits, when we'll re-check].
DOCTOR	[Team member] will walk you through the cost, the payment options and your superbill, and give it all to you in writing.
DOCTOR	You don't have to decide today. Take the estimate home. I'd rather you start when you're sure.

Your written financial policy (have it reviewed before you use it)

- ☐ One fee schedule that everyone sees.
- ☐ How and when superbills are given: same day, or a monthly roll-up.
- ☐ Accepted payment methods: cards, HSA and FSA cards, Cherry.
- ☐ Any time-of-service discount: modest, applied the same way to everyone, not advertised.
- ☐ Any package or short payment plan, written to your state's prepayment and refund rules.
- ☐ Who handles Medicare, Medicaid, auto and work-injury patients.
- ☐ When and how Good Faith Estimates go out.
- ☐ How refunds of unused prepaid care work.
- ☐ Reviewed by a chiropractic billing specialist (KMC University is one example) or a healthcare attorney.

FLORIDA EXAMPLE: THE 72-HOUR RULE

In Florida, any ad for a free, discounted or reduced-fee service by a chiropractor must carry a capital-letter statement (Fla. Stat. 456.062) that the patient has a right to refuse to pay, cancel payment or be reimbursed for other services performed as a result of, and within 72 hours of, responding to the ad. If your New Patient Special is advertised, ask a Florida healthcare attorney how same-day care plan sales, or a financing checkout on visit 1 or 2, fit that rule.

THREE PROMISES THE DOCTOR NEVER MAKES

Never promise results, a set number of visits to get better, or any reimbursement. Talk about what you found, what you recommend and what it costs. Then let the patient decide.

SUPERBILLS DONE RIGHT

A clean superbill is the most useful thing you can hand an insured patient. A sloppy or inflated one is a liability. Here's how to get it right.

A superbill is a detailed statement you give the patient instead of filing a claim with their insurance. It carries CPT and diagnosis codes, your NPI and tax ID, what was charged, what the patient paid, and a zero balance. The patient sends it to their insurer to ask for reimbursement or credit toward their deductible. KMC University puts it plainly: superbills are “not a workaround for payer contracts or Medicare rules.”

Think of it as the patient's version of a CMS-1500. The CMS-1500 is the standard paper claim form for professional providers, and the provider or its biller submits it. A superbill carries the same data, but the patient submits it, usually along with the insurer's own member claim form.

Superbill field checklist (built from what three major insurers ask for)

- ☐ Patient: name, date of birth, address, and the insured person's name and member ID.
- ☐ Provider: the rendering doctor's name and credentials (DC) and individual (Type 1) NPI.
- ☐ Practice: name, address, phone, tax ID (EIN), and group (Type 2) NPI if you're incorporated.
- ☐ Date of service for each line.
- ☐ Place of service code for each line (11 means Office).
- ☐ CPT or HCPCS code for each service, with any modifiers.
- ☐ Units for each code, which matters most for timed codes.
- ☐ ICD-10 diagnosis code(s), with a pointer from each service line to its diagnosis.
- ☐ Charge for each line, plus total charges.
- ☐ Any documented discount, shown as its own line.
- ☐ Amount paid, payment date, and a balance of \$0.
- ☐ Provider signature and date.
- ☐ A note that reads “Paid in full by patient. Not assigned.”
- ☐ Keep a current W-9 ready to give patients. UnitedHealthcare says one may be needed when the provider is out-of-network.

Why these fields? Cigna's member claim form asks for the professional's name and credentials, address, tax ID, a procedure code, the charge and an ICD-format diagnosis, and says it “can't accept receipts, balance due statements and cancelled checks” in place

of an itemized bill. UnitedHealthcare's member page asks for the tax ID, diagnosis codes, procedure codes with modifiers, units, the billed amount per code and the place of service code. Aetna's form asks for days or units, amount paid, a physician signature and the NPI. Cover all three and you've covered what these three major carriers ask for.

Chiropractic superbill template (layout example)

Section	What to fill in	Example format
Practice	Practice name, address, phone, tax ID (EIN), group NPI (Type 2) if incorporated	[Practice name] · EIN [number] · NPI [10 digits]
Provider	Rendering doctor, credentials, individual NPI (Type 1)	[Dr. Name], DC · NPI [10 digits]
Patient	Name, date of birth, address	[Patient name] · DOB [MM/DD/YYYY] · [Patient address]
Insured	Policyholder name and member ID	[Policyholder name] · Member ID [from card]
Diagnoses	ICD-10 codes, lettered so each line can point to the ones it treats	A: M99.01 (segmental dysfunction, cervical) · B: M99.02 (thoracic) · C: M99.03 (lumbar)
Line item	Date · place of service · CPT and modifier · diagnosis pointer · units · charge	[MM/DD] · 11 · 98941 · A, B, C · 1 · \$[your fee]
Line item	One line per service	[MM/DD] · 11 · [code] · [letter] · [units] · \$[your fee]
Totals	Total charges, any documented discount line, amount paid, balance	Total \$[x] · Discount \$[x] · Paid \$[x] · Balance \$0
Payment	Date and method of payment	[MM/DD/YYYY] · [card, HSA or FSA]
Sign-off	Provider signature and date, plus the not-assigned note	[Signature] · [Date] · Paid in full by patient. Not assigned.

ABOUT THE EXAMPLE CODES

The codes above show the layout only. Code 98941 means 3 to 4 spinal regions, so its line points to three regional diagnoses. The doctor picks every code from the documentation for that visit. Nothing in this template is coding advice.

YOUR SUPERBILL MUST MATCH REALITY

List only services actually provided that day, codes your notes support, and the amount the patient was actually charged and paid. If a patient paid [\$97] for your New Patient Special, the superbill shows [\$97] as the charge after any discount and [\$97] paid. What the insurer does with it is up to the insurer. Never list a higher "regular" fee as if it were paid, never hide a discount, and never pick codes or diagnoses to boost reimbursement. Federal health care fraud laws cover private plans, not just Medicare (18 U.S.C. 24(b) and 1035), and insurer claim forms carry state fraud warnings. The Florida notice on Cigna's form warns that anyone who knowingly, and with intent to defraud, files a claim with false, incomplete or misleading information commits a third-degree felony.

How should the fee appear? Experts differ. KMC University suggests listing your office fee, then the discount as its own line, then the amount paid. A Florida health law firm suggests billing everyone the same fee and accepting less as payment. Dynamic Chiropractic warns never to let any patient billing reflect "an amount higher than what they paid." All three agree on the part that matters: the superbill shows what the patient actually paid. Pick one format with a healthcare attorney or a chiropractic billing specialist and use it for every patient. KMC's rule of thumb is a good one: "your fee is your fee is your fee."

Coding rules that keep superbills clean

- The doctor chooses codes, not the front desk, and every code must be supported by the notes. Insurers can ask for records, and Cigna's form says so.
- Spinal manipulation codes: 98940 (1 to 2 regions), 98941 (3 to 4 regions), 98942 (5 regions). 98943 is extraspinal.
- Timed codes like 97110 and 97112 are billed in 15-minute units, and services under 8 minutes aren't reported (American Chiropractic Association). Supervised modalities like 97012 and 97014 aren't timed.
- An E/M visit on the same day as manipulation must be separate and distinct, with modifier 25. The American Chiropractic Association notes some payers deny almost all established-patient E/M codes billed with manipulation, even when modifier 25 is used correctly, a position the association calls extreme.
- New patient office E/M codes are 99202 to 99205. Code 99201 was deleted in 2021.
- ICD-10-CM codes update every October 1, with occasional April 1 updates, and CPT codes update every January 1. Review your template's code list at least once a year.

SAME DAY OR MONTHLY?

Offer the superbill by email the same day, or as one monthly roll-up statement. Monthly is simpler for patients in a care plan. Either way, remind patients that filing deadlines vary by plan.

PACKAGES: NEVER LET A SUPERBILL SHOW \$0 PAID

If patients prepay a package, allocate the payment to each visit. Jane App, a practice-management system, notes that packages paid upfront with a \$0 per-visit price produce superbills showing the patient paid \$0. That superbill won't do the patient any good.

At checkout

- | | |
|-------------------|---|
| FRONT DESK | Here's your superbill for today. It's an itemized receipt with the codes your insurance asks for. |
| FRONT DESK | If your plan has out-of-network benefits, you can send it in with their member claim form. I can't promise what they'll pay, but here's our one-page guide on how to submit it. |
| PATIENT | Do I sign the part that says pay the provider? |
| FRONT DESK | No. You've already paid us, so leave that part blank. That way any reimbursement is sent to you. |

OPTIONAL: COURTESY FILING

Cigna and UnitedHealthcare both say an out-of-network provider can still file the claim for the patient. Some practices offer courtesy filing: you send an unassigned claim, and the insurer pays the patient. KMC says a self-submitted superbill claim should be marked "not assigned." If you offer this, decide who owns it on your team, and present it as a service, never a promise of payment. Before you offer it: filing claims electronically makes your practice a HIPAA covered entity if it isn't already. Florida example: the fee on any claim you submit must match the fee you advertise (Fla. Stat. 460.413(1)(bb)). Have your billing specialist or healthcare attorney set the fee format before the first claim goes out.

PRIVACY

Superbills contain protected health information. Email or text them only through your HIPAA-compliant channel, or the way the patient has asked in writing. That's our recommendation, not a legal ruling, so check it against your practice's HIPAA policy.

What about apps that file claims for patients? They exist, but we aren't recommending one yet. Reimbursify lists specialties like mental health and physical therapy but did not list chiropractic when we checked. Thrizer is built for therapists. If a vendor confirms in writing that it supports chiropractic claims, it may be worth a look.

THE PATIENT REIMBURSEMENT SOP

Your superbill only helps if the patient actually sends it in. Make the next steps so clear they can't get lost.

Here's the honest pitch: you can't promise a patient anything about reimbursement, but you can make the process easy. That alone sets you apart from the office that says "no" and moves on. Everything below also appears in the print-ready patient handout at the end of this guide.

For the patient: check benefits before the first visit

1. Look up "Chiropractic care" in your Summary of Benefits and Coverage. Every plan's SBC must list it as either covered or not covered. The SBC also shows the plan's general out-of-network deductible and cost sharing, though it may not show a chiropractic-specific amount.
2. Try your insurer's online cost estimator. Under federal price transparency rules, it may show an out-of-network allowed amount for covered services. Search a code like 98941.
3. Call the member services number on the back of your card and ask the questions below.
4. Write down the rep's name, the date and the call reference number.

Questions the patient asks their insurance company

- ☐ Is my plan an HMO, EPO, PPO or POS?
- ☐ Do I have out-of-network benefits for chiropractic care, codes 98940 to 98942, place of service 11 (office)?
- ☐ What is my out-of-network deductible, and how much have I met? When does my plan year reset?
- ☐ What coinsurance applies after the deductible?
- ☐ What is my out-of-network out-of-pocket maximum?
- ☐ Is there a yearly chiropractic visit limit, and is it shared between in-network and out-of-network care?
- ☐ Do I need prior authorization or a referral?
- ☐ Is my chiropractic benefit managed by another company?
- ☐ How do I submit a member claim (online or by mail), and which form do I use?
- ☐ What is my filing deadline?
- ☐ Who gets paid: me or the provider?

WHY ASK WHO MANAGES THE BENEFIT?

Some insurers hand chiropractic to a separate company. For example, Cigna delegates chiropractic network management, medical necessity review and claims processing to American Specialty Health (ASH) for many Cigna plans. That company may have its own rules and forms.

How the patient submits a superbill

1. Log in to your insurer's member portal and find "Submit a claim," or download the member medical claim form.
2. Fill in the member section. Leave the "pay the provider" or assignment of benefits section blank, because you already paid.
3. Attach the superbill and proof of payment. Keep copies of everything.
4. Upload it, or mail it to the claims address on your ID card.
5. Submit monthly, or as soon as you can. Filing deadlines vary by plan.
6. Watch for your Explanation of Benefits (EOB). If the claim is denied, call the insurer, ask why, and ask about the appeal process.

DEADLINES ARE PLAN BY PLAN

Member filing deadlines vary widely. Cigna's form says within 180 days of service unless the plan or state law allows more. For its individual marketplace plans, Florida Blue says it must receive a member claim within 90 days of service, and generally won't consider one received more than a year after service. UnitedHealthcare says it "can take up to 30 days" to get a check after a claim is processed. So don't print one universal deadline, and don't print insurer phone numbers or addresses. Send patients to their card and their member portal.

Front-desk SOP

- Run, or coach the patient through, the benefits call before visit 1.
- Hand over or email the superbill at checkout, or send a monthly roll-up.
- Give every new cash patient the one-page handout. A QR code on a front-desk sign works too.
- Log each superbill in your CRM with the date sent.
- At 30 days, check in: "Did you hear back from your insurance? Anything we can help with?"
- If an insurer asks for records, route it to the doctor.

- If a patient signed the assignment box by mistake and the insurer pays you, flag it to the office manager right away so the patient is refunded promptly. Florida example: practitioners who file claims must refund patient overpayments within 30 days of determining one (Fla. Stat. 456.0625). Ask your attorney how that applies to you.

MAKE IT EASIER

Put a QR code to the handout at the front desk and on your website. Link to the member claim form pages of the 4 or 5 biggest carriers in your area, on the insurers' own sites so the forms stay current. And give every self-pay patient a Good Faith Estimate and a signed self-pay election (a form saying the patient is paying and not asking you to bill insurance) at intake.

MEDICARE, MEDICAID AND OTHER EXCEPTIONS

This is where cash practices get in trouble. The superbill path is for commercial insurance. Everyone else needs a different conversation.

FRONT DESK SHORT VERSION

Medicare caller: no cash quote, hand off to [Team member]. Medicaid caller: ask them to call their plan first. Car accident or work injury: get the date and route to [Team member].

MEDICARE IS DIFFERENT. FULL STOP.

Chiropractors cannot opt out of Medicare. The Medicare Benefit Policy Manual says the opt-out law "does not define physician to include chiropractors." Being non-participating doesn't get you out of billing either. If you give a Medicare patient a service Medicare covers (spinal manipulation for active, corrective care), federal law requires you, not the patient, to file the claim, and you cannot charge a fee for filing it. A superbill is not a Medicare workaround.

What Medicare covers from a chiropractor

- Only manual manipulation of the spine to correct a subluxation (98940 to 98942, with the AT modifier for active or corrective care).
- The patient pays 20% of the Medicare-approved amount after the Part B deductible.
- Everything else a chiropractor furnishes or orders is not covered, including exams, X-rays and therapies.
- Maintenance care, once further clinical improvement can't reasonably be expected, is not considered medically necessary. To bill the patient for maintenance manipulation, give a valid Advance Beneficiary Notice (ABN) before the service and add the GA modifier to the claim. One ABN can cover a repeated service for up to a year if it names the service and frequency.
- Exceptions to filing are narrow. The two a chiropractor sees most: the patient freely refuses to authorize a Medicare claim for covered care (Medicare's charge limits still apply), or, for care Medicare won't cover such as maintenance, the patient picks Option 2 on a valid ABN signed before the service. Have a Medicare billing specialist set your policy.
- Non-participating providers who don't accept assignment can't collect more than the limiting charge, which is 115% of the non-participating payment amount.

Violating mandatory claim submission can bring civil money penalties and exclusion from Medicare. Health-law commentary also holds that there's no "cash practice exception" for covered active care if you aren't enrolled. That last point is legal interpretation, not a single CMS sentence, so talk to a healthcare attorney before you see Medicare patients for cash.

Medicare Advantage plans have their own rules. KMC University warns that a non-network chiropractor should charge a Medicare Advantage patient directly only after confirming the patient isn't in a Private Fee-for-Service plan and isn't a Qualified Medicare Beneficiary (QMB). Bring in a Medicare billing specialist before you set a policy.

Medicaid: chiropractic is an optional benefit, so each state decides whether and how much to cover. Providers who take part in Medicaid must accept Medicaid's payment, plus any required cost sharing, as payment in full. Patients can't always submit their own claims either; that depends on the state plan. Florida example: a Medicaid provider must tell a recipient before each service that they're responsible for services Medicaid doesn't cover, and may bill the recipient only in listed situations. The simple front-desk move: ask the patient to call their plan first.

Auto accidents and work injuries (Florida examples): PIP pays medical benefits only if initial care is received within 14 days of the accident, and it has its own limits and rules. Florida workers' compensation law says a provider "may not collect or receive a fee from an injured employee" except as that chapter allows. A superbill is the wrong tool for either one. Give them their own intake path.

NEVER WAIVE COPAYS OR ADVERTISE "NO OUT-OF-POCKET"

The HHS Office of Inspector General says routinely waiving Medicare copays or deductibles is unlawful, and it lists marketing like "Insurance Accepted As Payment in Full" and "No Out-Of-Pocket Expense" as suspect. Florida example: making a practice of billing a usual fee while waiving deductibles or copays is insurance fraud (Fla. Stat. 817.234(7)(a)), and offering to accept whatever insurance pays as payment in full, when it gives the impression the deductible is eliminated, is grounds for discipline (Fla. Stat. 460.413(1)(z)).

SPECIALS AND GIFTS FOR MEDICARE AND MEDICAID PATIENTS

Offering Medicare or Medicaid patients anything likely to influence their choice of provider can bring civil money penalties. That includes copay waivers and services given free or below fair market value. OIG's nominal-value safe zone is gifts of no more than \$15 per item and \$75 per patient per year, and never cash or cash equivalents. A common practice to discuss with counsel: add "Offer not available to Medicare, Medicaid or other federal health care program beneficiaries" to your New Patient Special.

PAYMENT OPTIONS THAT KEEP THE CONVERSATION GOING

When the answer to “Can I use my insurance?” is “not directly,” the same sentence should carry the fix that fits their plan. For a PPO, that's the superbill. For an HMO or EPO, which usually won't pay out of network, it's cards, HSA and FSA cards, and a Cherry payment plan. Here are the options, what to say, and what to watch.

If the front desk only says “No, we're cash, but we have a New Patient Special,” the call ends. A practice that can answer with a clear price, a way to use HSA money, a superbill and a payment plan gives the caller a reason to stay on the phone. On the phone, lead with the fix that fits the caller's plan, like the superbill for a PPO, and keep the rest of this menu ready if cost comes up. Financing and packages are options the patient can choose, never the default.

The payment options menu

Option	Best for	Watch out for
Clear pricing and a Good Faith Estimate	Everyone paying out of pocket	Required anyway for self-pay patients. Post the notice.
HSA or FSA card	Patients with a health account	FSA charges may need a receipt. No tax advice from staff.
Superbill	PPO patients with out-of-network benefits	Never promise reimbursement.
Short in-house plan (4 payments or fewer, no interest or fees)	Patients who need a few weeks	More installments or any fee can make you a lender.
Cherry patient financing	Longer plans, HMO or EPO patients, unmet deductibles	Eligibility isn't guaranteed. Follow financing ad rules.
Package pricing	Patients starting a longer care plan	State prepayment, trust and refund rules.

Option	Best for	Watch out for
CareCredit (if they already have it)	Existing cardholders	Deferred interest on promotional plans.

Option 1: clear pricing and a Good Faith Estimate

FRONT DESK Your first visit is [\$97], and you'll get the cost in writing too. I've got [day] at [time] or [day] at [time]. Which is better?

Under the No Surprises Act, you owe a written Good Faith Estimate to uninsured and self-pay patients, and “self-pay” includes insured people who aren't asking you to bill their plan. Many cash practices assume it only covers the uninsured. It doesn't. Post a notice that GFEs are available on your website, in the office and wherever scheduling happens, and say it out loud when cost comes up. One GFE can cover a care plan of up to 12 months, and a patient can dispute a bill that runs \$400 or more over it. Medicare and Medicaid patients are generally excluded. For services Medicare doesn't cover, such as a chiropractor's exam, giving a GFE anyway is the safer habit. Treat it as a trust signal: a written number answers the money question directly.

SUPERBILL PATIENTS AND THE GFE

CMS hasn't said directly whether a patient who plans to file their own superbill counts as self-pay. The safe habit, and what billing educators like KMC University recommend, is a signed self-pay election and a GFE for every cash patient. Confirm your approach with a healthcare attorney.

Option 2: HSA and FSA cards

FRONT DESK We take HSA and FSA cards, and you get an itemized receipt every visit in case your plan asks for one. I've got [day] at [time] or [day] at [time]. Which is better?

HSA and FSA: what the owner needs to know

- The basis: IRS Publication 502 says “You can include in medical expenses fees you pay to a chiropractor for medical care.”

- HSA money covers expenses only to the extent they aren't paid by insurance (IRS Publication 969). A patient who pays with an HSA and later gets reimbursed by their insurer should talk to their account administrator or tax advisor. Your team should not give tax advice.
- FSA card charges that aren't automatically verified stay pending until the patient sends proof, like a receipt showing the service, date and amount (IRS Notice 2006-69). Itemized receipts every visit help.
- FSA and HRA cards work only at merchants with health care merchant category codes. Ask your card processor to confirm your practice is coded 8041 (Chiropractors).
- FSA plans count an expense when the care is provided, not when it's paid (proposed Treas. Reg. 1.125-6), so an FSA card charge for a prepaid package may be denied or need to be paid back. For FSA patients, charge per visit or allocate the package to each visit. For HSAs and the tax deduction, IRS Publication 502 says payments for care to be provided substantially beyond the end of the year generally can't be counted. Ask patients to check with their plan administrator before using an HSA or FSA for a package.
- FSA money generally must be used within the plan year, with a grace period or carryover only if the employer offers one.
- Never market a membership as HSA-eligible. The new HSA rule for direct primary care (from the 2025 One Big Beautiful Bill Act, explained in IRS Notice 2026-5) covers only family, internal, geriatric and pediatric medicine physicians, nurse practitioners, clinical nurse specialists and physician assistants. Chiropractors aren't included.

Option 3: the superbill

FRONT DESK We're out of network, so what we do is give you a superbill. It's a detailed receipt you send in to your insurance, and depending on your plan, they may count it toward your out-of-network deductible or pay you back for part of it. We do this all the time. When you come in, we'll give you the instructions for sending it in.

Option 4: a short in-house plan

FRONT DESK If paying all at once is tough, we can split it into up to four payments, with no interest or fees.

KEEP IN-HOUSE PLANS SHORT AND SIMPLE

Under Regulation Z (Truth in Lending), a business that regularly extends consumer credit with a finance charge, or payable in more than four installments, can become a "creditor." Keeping in-house plans to four payments or fewer with no interest or fees generally avoids that. Autopay from a bank account needs the patient's signed authorization, and you must give them a copy (Regulation E). Longer or interest-bearing plans belong with a financing company.

Option 5: Cherry. Cherry is a patient financing platform that lists chiropractic among its supported specialties. Full disclosure: CHIROBASIX is building a partnership with Cherry, so weigh our take with that in mind. Here's what Cherry says about itself on withcherry.com as of September 2026. These are the company's own statements and can change, so re-check them before you rely on them.

What Cherry says

- It is "a financial technology provider and platform, not a bank or a lender." Cherry says its loans are made by Lead Bank, Member FDIC, and that some plans are retail installment contracts extended by the practice itself.
- Checking eligibility uses a soft credit check that doesn't affect the patient's credit score. Cherry also reports plan status to Equifax, TransUnion and Experian, so missed payments can show up on a credit report.
- Plans run 0% to 35.99% APR, over 1 to 60 months, for \$35 to \$65,000. 0% and other promotional rates depend on eligibility, and eligibility isn't guaranteed. A 0% APR rate holds only while payments are on time: Cherry says that if an account becomes delinquent, interest may apply going forward.
- Approved patients are offered an interest-free pay-in-four option, and Cherry's homepage says it charges no deferred interest. Its disclosures also describe a Waived Interest Promotion that some practices opt into: interest builds and is credited back only if the full balance is paid by the promotion end date, with every payment made within 15 days.
- A down payment is due at checkout, there's no fee for paying early, and a late fee may apply if a payment isn't received within 15 days.
- For the practice: free sign-up, a merchant fee deducted before payout that varies by plan type and volume, payment in 2 to 3 business days, and Cherry services repayment.

Option 5: offering Cherry

FRONT DESK

We also work with Cherry for payment plans. Cherry says checking if you qualify won't affect your credit score, and some plans are 0% APR if you're approved and pay on time. Other plans can carry interest. Want me to text you the link?

Set up Cherry in your practice

- ☐ 1. Sign up at withcherry.com/business and get your practice's unique application link.
- ☐ 2. Ask your Cherry rep, in writing, for your exact merchant fee, which plan types and structure your practice will use (a Lead Bank loan or a retail installment contract with your practice as the seller), whether any plan has recourse to your practice, and how refunds for unused care are handled.
- ☐ 3. Put the link on your booking page and your Insurance and Payment Options page.
- ☐ 4. Save the link as a text snippet in your CRM so staff can send it to patients who asked about cost and agreed to texts. Patient texts, emails and your website should always use your practice's own Cherry application link.
- ☐ 5. Use only Cherry-approved ad and signage language.

FINANCING AD RULES AND FAIR PLAY

Truth in Lending ad rules apply to anyone who advertises consumer credit, including your office. If an ad or web page states a monthly payment, number of payments, down payment or finance charge, it must also state the down payment, the full repayment terms and the APR. "As low as \$X a month" on its own is not compliant. In 2023 the CFPB reported that medical credit cards carry interest rates well above regular credit cards (26.99% versus 16%), and that lenders give provider offices marketing training to offer them. Cherry's own APR range runs from 0% to 35.99%. Present Cherry as one option alongside cards, HSA or FSA and paying per visit, never as the default. Link only to withcherry.com or the practice link Cherry gives you, so patients land on the real site. California example: before your team helps a patient apply for any third-party financing, Bus. & Prof. Code 654.3 requires a written treatment plan with estimated costs and a signed notice, bars charging for care more than 30 days before it's provided, and bars arranging open-end credit with deferred interest. Other states have their own rules.

Option 6: package pricing

FRONT DESK

If you'll be coming for a while, we offer a package price for a set number of visits, and if you stop early we refund what you haven't used.

PACKAGE RULES VARY A LOT BY STATE

Depending on your state, you may owe pro-rata refunds, need an escrow or trust account, have to offer a cancellation window, or need specific written disclosures. Examples: Florida treats patient money over \$501 advanced for future treatment as trust funds, held in a separate trust account under Board rule, with complete records, and delivered to the patient on request. The old \$1,500 cap on advances was removed effective July 1, 2026. Texas allows prepayment only if either side can cancel any time without penalty, unused fees are refunded pro rata, and the plan covers a defined number of visits. Texas proposed a broader rewrite in July 2026 that would cover memberships and payment plans; check whether it has been adopted. Washington requires a complete refund for care not received. Minnesota treats prepaids of \$1,000 or more as regulated plans with an escrow account and a 3-business-day right to cancel. Check your state's rules before you sell packages.

Option 7: CareCredit, if they already carry it

FRONT DESK If you already have a CareCredit card, you can use it here. Just know the promo plans add back interest if the balance isn't paid off by the end date.

CareCredit is a credit card issued by Synchrony Bank. Its promotional financing is deferred interest: interest builds from the purchase date and is added if any promo balance remains at the end. Prequalifying is a soft check, but moving on to apply triggers a hard credit inquiry. Its chiropractic page says packages and treatment plans must be completed within 90 days of the first transaction, though select providers can offer other time periods.

MEMBERSHIPS: ASK YOUR ATTORNEY FIRST

Depending on the state and how it's set up, a prepaid or unlimited-care plan can raise insurance or discount-plan licensing questions. That's why Florida created a specific exemption for written direct health care agreements, which must state "This agreement is not health insurance" (Fla. Stat. 624.27), and separately regulates discount plans that include chiropractic. Memberships sold online with automatic renewal also fall under the federal Restore Online Shoppers' Confidence Act (ROSCA), and many states, Florida included, have auto-renewal laws. Never describe a membership as "like insurance," and never market it as HSA-eligible.

TIME-OF-SERVICE DISCOUNTS

Keep them modest, tied to real billing savings, applied the same way to every patient, and not advertised. Never give a cash discount on a visit you are also billing to insurance, and if you're in network with any payer, check those contracts first. You may hear that the OIG approves a specific discount percentage; we couldn't find that in any OIG primary source, so don't rely on it. Florida example: advertising a fee that differs from the fee you submit to third-party payors is grounds for discipline (Fla. Stat. 460.413(1)(bb)).

STOP THE OBJECTION BEFORE THE PHONE RINGS

The best time to answer the insurance question is before anyone dials. Put the answer everywhere a patient looks.

People search this question directly. SEMrush estimated (US, September 2026) about 2,400 monthly searches for “do chiropractors take insurance” and about 260 for “how much is a chiropractor without insurance.” If your website doesn't answer it, the caller brings the question to your front desk instead.

Your Insurance and Payment Options page

- ☐ Say plainly that you're an out-of-network practice and don't bill insurance directly.
- ☐ Explain superbills in two sentences, with a link to the patient handout.
- ☐ List payment methods: cards, HSA and FSA cards, and Cherry if you offer it.
- ☐ Show your first-visit price and what it includes.
- ☐ Post the required Good Faith Estimate notice.
- ☐ Add a line for Medicare, Medicaid, auto and work-injury patients: “Call us so we can explain how billing works for your situation.”
- ☐ Answer “Do you take insurance?” in a 30 to 50 word FAQ.
- ☐ Link the page from your header, footer and booking page.

SAMPLE FAQ ANSWER FOR YOUR SITE

Do you take insurance? We're out-of-network, so we don't bill insurance directly. You pay at your visit and get a superbill to send your insurer. Whether they reimburse you depends on your plan. We also accept HSA and FSA cards and offer Cherry payment plans for those who qualify.

Google Business Profile

- Leave the “Accepted health insurance” field empty. Never list networks you aren't in.
- In your description, add a line like “Out-of-network practice. Superbills provided. HSA and FSA accepted.” Leave prices out: descriptions can't focus on promotions or prices, can't include links, and max out at 750 characters.
- Put your New Patient Special in Posts, with any required disclosures.

- Don't count on Q&A. Google discontinued the Business Profile Q&A API in November 2025, and reports say AI answers drawn from your website, profile and reviews are taking its place. Put the answer on your website.

Google Ads

- Add phrase-match negative keywords like "accepts insurance," "takes insurance," "in network," "covered by," "medicaid and medicare. Don't add "insurance" on its own, or you'll block searches like "chiropractor without insurance."
- Review the search terms report every month.
- If your account is eligible for Google lead form assets (Google's lead form policy excludes healthcare-related ads, so many chiropractic accounts are not), add a qualifying question such as "How do you plan to pay?" with choices like Self-pay or HSA/FSA, Want to use out-of-network benefits, or Only in-network insurance. Otherwise, put the same payment-preference question on your landing-page form.
- Ask about payment preference only. Never ask about coverage details or health conditions.

Meta (Facebook and Instagram)

- Don't ask for insurance information on Instant Forms. Meta doesn't allow insurance or health questions without its prior permission.
- Put "Out-of-network. Superbills provided." in the ad copy or on the form's intro screen.
- Test the Higher intent form type, which adds a review step before someone submits.

On landing pages, state your payment model above the fold, right next to the offer. A caller who already knows you're out-of-network before they dial won't be surprised when your front desk says it.

FLORIDA EXAMPLE: RULES FOR YOUR NEW PATIENT SPECIAL AD

Florida requires a chiropractor's ad for a free, discounted or reduced-fee service to state the usual fee prominently (Fla. Stat. 460.413(1)(cc)) and to include this statement in capital letters (Fla. Stat. 456.062): THE PATIENT AND ANY OTHER PERSON RESPONSIBLE FOR PAYMENT HAS A RIGHT TO REFUSE TO PAY, CANCEL PAYMENT, OR BE REIMBURSED FOR PAYMENT FOR ANY OTHER SERVICE, EXAMINATION, OR TREATMENT THAT IS PERFORMED AS A RESULT OF AND WITHIN 72 HOURS OF RESPONDING TO THE ADVERTISEMENT FOR THE FREE, DISCOUNTED FEE, OR REDUCED FEE SERVICE, EXAMINATION, OR TREATMENT. The FTC also expects the terms of any free offer to appear clearly at the start of the offer, not in an asterisked footnote. If you test a lower special, keep both Florida disclosures and have a Florida healthcare attorney review it before launch. Other states have their own rules.

THE FOLLOW-UP SYSTEM AND SLOW-SEASON PLAYBOOK

This is the part most practices skip. A caller who said “insurance” today can still become a patient next month, if somebody follows up.

Remember the practice from Part 1? The bigger fix wasn't the script. It was the season and the follow-up. Great scripts can't fix a lead nobody calls back.

SPEED MATTERS

A Harvard Business Review study published in 2011 analyzed 1.25 million leads at 42 US companies. It found that firms that tried to contact a web lead within an hour were nearly 7 times as likely to qualify it as firms that tried even an hour later, and more than 60 times as likely as firms that waited 24 hours or more. In a separate audit of 2,241 US companies, 23% never responded to a web lead at all. It's general sales research, not chiropractic data, but the lesson travels.

Speed-to-lead setup in your CRM

- ☐ Turn on missed-call text back, an automatic text to anyone whose call you miss. Keep it a short, non-promotional reply only, such as: “Hi, this is [Practice]. Sorry we missed your call. How can we help? Reply STOP to opt out.” Leave offers, prices and financing out of that text.
- ☐ Call form leads back within minutes during office hours, and within the hour at most.
- ☐ Tag every call where insurance comes up as insurance-objection.
- ☐ Log a follow-up task for every “I need to think about it,” on the day the caller picked.
- ☐ Build a 10 to 14 day new-lead sequence (call, text, email).
- ☐ Build a separate, longer nurture for insurance-first contacts.
- ☐ Add consent language to your web forms and CRM forms.

Sample follow-up sequence for insurance-first leads

When	Channel	What to send
Same day	Call, then text (only with a clear yes)	Thanks for calling, plus the three questions to ask their insurance.

When	Channel	What to send
Same day, if no answer	Voicemail	Name, practice and number only. No health details.
Day 2	Email	"The 3 questions to ask your insurance company" (below).
Days 4 to 14	Call and text	A check-in, the HSA, FSA and Cherry options, and a booking link.
Day 30	Email	How to check your out-of-network benefits.
Day 60	Email	How to read your Explanation of Benefits (EOB).
Day 90	Email	A friendly check-in and your first-visit details.

Voicemail (calling back a lead who hung up)

FRONT DESK Hi [first name], this is [Your name] with [Practice], returning your call. I've got a couple of options that might help with the question you asked. Give me a call or text back at [phone]. Again, that's [phone]. Hope to talk soon.

Same-day texts (only if they said yes to texts)

FRONT DESK (SHORT TEXT) Hi [first name], it's [Your name] at [Practice]. Thanks for calling today. Insurance questions are totally normal. Want me to send the 3 questions to ask your insurance so you know your options? Reply YES. Reply STOP to opt out.

FRONT DESK (LONGER TEXT) Hi [first name], it's [Your name] at [Practice]. Thanks for calling today. Here's how a lot of our patients handle insurance: we give you a superbill to send your insurance, and depending on your plan, they may count it toward your out-of-network deductible or pay you back for part of it. We also take HSA and FSA cards and offer Cherry payment plans (subject to approval). Want to grab a time? [link] Reply STOP to opt out.

Day 2 follow-up email

SUBJECT	The 3 questions to ask your insurance company
EMAIL	Hi [first name],
EMAIL	[Your name] here from [Practice]. You called us on [day] and asked about using your insurance. Here's how that works.
EMAIL	We're out-of-network, which means we don't bill insurance directly. But your insurance may still help. After each visit we give you a superbill: an itemized receipt with the codes insurance companies ask for. If your plan has out-of-network benefits, you can send it in, and they may pay you back part of what you paid. Every plan is different, so we can't promise what yours will do.
EMAIL	To find out, call the member services number on your insurance card and ask:
EMAIL	1. Do I have out-of-network chiropractic benefits?
EMAIL	2. How much of my out-of-network deductible have I met this year?
EMAIL	3. Do I need a referral or preauthorization first?
EMAIL	Other ways patients pay: debit or credit card, HSA or FSA card, or a payment plan through Cherry. Cherry says checking if you qualify won't affect your credit score, and approval isn't guaranteed.
EMAIL	Your first visit is [\$97] and includes [what's included]. You'll get the full cost in writing before any care plan starts.
EMAIL	Want to come in? Reply to this email or book here: [link]. And if now isn't the right time, no pressure. We'll be here.
EMAIL	[Your name], [Practice], [Phone] · [Physical mailing address] · [Unsubscribe link]

CONSENT AND CONTACT RULES

Get a clear yes before texting, include “Reply STOP to opt out,” and honor STOP right away. Under the FCC's consent-revocation rule, replies like STOP, QUIT, CANCEL or UNSUBSCRIBE revoke consent, and opt-outs must be honored within 10 business days. Marketing texts generally need prior express written consent, and business texting from a 10-digit number requires A2P 10DLC registration. Florida example: Florida's Telephone Solicitation Act counts marketing texts as telephonic sales calls and requires prior express written consent for automated ones (Fla. Stat. 501.059). Separately, the Florida Telemarketing Act bars commercial telephone solicitation calls before 8 a.m. or after 8 p.m., and more than 3 in 24 hours on the same subject (Fla. Stat. 501.616), with exemptions listed in 501.604. The simple habit: follow the same hours and limits for calls and texts. Emails need your physical mailing address and a working unsubscribe link, with opt-outs honored within 10 business days. Voicemails: leave only your name, office and number.

The slow-season playbook

- Check the season first. Pull 24 months of new patients by month before you blame the calendar. Seasonal patterns, like snowbird months in warm-weather markets, are plausible, but your own data decides.
- Reactivate. Run a campaign to patients last seen 6 to 24 months ago. Send reactivation texts only to patients who gave written consent to texts. Use email for everyone else.
- Referrals. Run a referral campaign, but have counsel review any reward first. Florida example: the Patient Brokering Act applies to all payers, not just Medicare.
- Teach. In slow months, run workshops, events, educational videos and emails.
- Q4: the FSA reminder. FSA money generally must be used within the plan year, so a “check your FSA balance” message fits. Plan years and grace periods vary, so don't assume December 31.
- New plan year: deductible education. Deductibles reset each plan year, and plan years don't always start in January. Explain it; don't overstate it.

THINKING ABOUT A LOWER NEW PATIENT SPECIAL?

Test it only after the script changes are in place, and change one thing at a time. Get 30 days of baseline data before you touch the offer. Every discount must trace back to your fee schedule, and in Florida the ad still needs the usual fee and the 72-hour statement.

TRACK IT

You can't fix what you don't count. One simple weekly tally tells you whether the scripts are working.

Start with a 30-day baseline before you change your offer, your ads or your price. Then change one thing at a time, so you know what actually moved the number.

Weekly insurance-objection tally

Week of	Insurance calls	Booked	Shown / started	Top lead source	Who / script / notes
[Date]	[#]	[#]	[#] / [#]	[Source]	[Name / version / what you heard]
[Date]	[#]	[#]	[#] / [#]	[Source]	[Name / version / what you heard]
[Date]	[#]	[#]	[#] / [#]	[Source]	[Name / version / what you heard]
[Date]	[#]	[#]	[#] / [#]	[Source]	[Name / version / what you heard]

How to run it

- ☐ Tag every call where insurance comes up as insurance-objection in your CRM.
- ☐ Track each tagged contact through booked, showed and started care.
- ☐ Split results by lead source, by staff member and by script version.
- ☐ Listen to 5 recorded calls a week and note where callers drop off. Before you record anything, turn on your phone system's recording announcement, such as: "This call may be recorded for quality and training." Florida, California and several other states require everyone on the call to consent, and recording without it can be a crime. Store recordings as securely as any patient record.
- ☐ Report the weekly insurance-objection booking rate next to lead source.
- ☐ Check superbill follow-ups at 30 days: did the patient submit, and do they need help?

THE ONLY MATH YOU NEED

Booking rate = booked ÷ insurance calls. Watch the trend over several weeks, not a single week.

YOUR 7-DAY ACTION PLAN

Take on one focus a day. By next week, your team will sound different on the insurance call.

This week

- ☐ Day 1: Sort your callers. Add the “Who is calling?” question to your front-desk script: plan through work or on their own (and whether it's a PPO, HMO or EPO), Medicare, Medicaid, car accident or work injury, or no insurance. Then name who handles your Medicare calls and your accident calls.
- ☐ Day 2: Rehearse the scripts. Print Part 3, cut any line that isn't true for your office, and role-play the insurance objection out loud with your team.
- ☐ Day 3: Fix your superbill. Check your template against the field checklist, allocate package payments per visit, and have a billing specialist confirm how you show fees and discounts.
- ☐ Day 4: Print the patient handout. Add your practice details, put copies at the front desk, and add a QR code that links to it.
- ☐ Day 5: Fix your Good Faith Estimate workflow. Post the notice on your website and in the office, add the GFE line to your phone script, and set your CRM to send one after a cost question or booking.
- ☐ Day 6: Turn on follow-up. Switch on missed-call text back with a short, non-promotional reply, add the insurance-objection tag, turn on the call recording announcement, and load the text and email sequence with consent language.
- ☐ Day 7: Publish your answer. Add an Insurance and Payment Options page with the FAQ, update your Google Business Profile description, add ad negative keywords, and start your weekly tally.

CHIROBASIX CLIENTS

Talk to your account manager about building this into your ENGAGE follow-up, your website and your ads. The scripts work best when the follow-up behind them actually runs.

ONE LAST REMINDER

Before you launch anything that changes pricing, packages, memberships, financing or ads, confirm it with your state chiropractic board, a healthcare attorney or a certified billing and coding specialist. Rules vary by state and by plan, and they change.

HOW TO USE YOUR SUPERBILL FOR OUT-OF-NETWORK REIMBURSEMENT

We're an out-of-network practice, so we don't bill your insurance directly. After you pay, we give you a superbill: an itemized statement with the codes insurance companies ask for. You can send it to your insurance company yourself. Whether you're reimbursed, and how much, depends on your plan. Here's how to find out, and how to submit it.

Step by step

1. Know your plan type. HMO and EPO plans usually don't cover out-of-network care except emergencies. PPO plans let members see out-of-network providers at an additional cost.
2. Look up "Chiropractic care" in your Summary of Benefits and Coverage, and try your insurer's online cost estimator.
3. Call the member services number on the back of your insurance card and ask the questions on this page. Write down the rep's name, the date and the call reference number.
4. After your visit, get your superbill from our front desk, the same day or as a monthly statement.
5. Log in to your insurer's member portal and choose "Submit a claim," or download their member medical claim form.
6. Fill in the member section. Leave the "pay the provider" or assignment of benefits section blank, because you've already paid us.
7. Attach your superbill and proof of payment. Keep copies of everything.
8. Upload it, or mail it to the claims address on your insurance card.
9. Send it in monthly, or as soon as you can. Deadlines vary by plan, and some plans require claims within 90 days.
10. Watch for your Explanation of Benefits (EOB). If a claim is denied, call your insurer, ask why, and ask about the appeal process.

Questions to ask your insurance

- ☐ Is my plan an HMO, EPO, PPO or POS?
- ☐ Do I have out-of-network benefits for chiropractic care (codes 98940 to 98942, place of service 11)?
- ☐ What is my out-of-network deductible, and how much have I met this year? When does my plan year reset?
- ☐ What coinsurance do I pay after the deductible?
- ☐ What is my out-of-network out-of-pocket maximum?
- ☐ Is there a yearly limit on chiropractic visits?
- ☐ Do I need a referral or prior authorization?
- ☐ Is my chiropractic benefit managed by another company?
- ☐ How do I submit a claim myself, and which form do I use?
- ☐ What is my filing deadline?
- ☐ Will any payment come to me or to the provider?

What you'll need

- Your superbill from our office (it lists dates, codes, charges and what you paid)
- Proof of payment, such as your receipt
- Your insurer's member claim form, if they use one
- Your member ID from your insurance card

Questions about your superbill? Call [Practice] at [phone] or email [email]. Ask for [Team member].

We can't guarantee reimbursement. Your insurance company decides whether to pay you back, and how much, based on your plan's out-of-network benefits, deductible, coinsurance, allowed amount, visit limits and medical necessity rules. Payment is based on your plan's allowed amount, which may be less than what you paid. Your superbill shows exactly what you were charged and what you paid. Medicare, Medicaid, auto accident and work injury claims follow different rules, so please ask our front desk. If you pay with an HSA or FSA, check with your account administrator before also seeking reimbursement from your insurer. This handout is general information, not insurance, legal or tax advice.

WANT HELP WITH THE OTHER HALF?

SCRIPTS WIN THE CALL. MARKETING DECIDES WHO CALLS.

CHIROBASIX builds the websites, ads, follow-up and content that bring in patients who already understand how a cash practice works. If you want us to look at where your insurance-first calls are coming from, book a free call.

Book A Free Strategy Call

This guide is general education for practice owners, not legal, billing or tax advice. Insurance, Medicare, Medicaid and state rules vary and change. Confirm anything you rely on with a healthcare attorney, a billing specialist or your state board.