Non-Covered Services: Financial Disclosure Form

Provider Name: ____________________________
Address: ___________________________ **City:** ___________________________ **State:** ________ **Zip:** _________
Phone Number: (______) _________________

As your Doctor of Chiropractic, I want to provide you with the best care possible. While your policy covers some chiropractic services, there may be others that I feel would help the treatment of your condition and maintenance of good health, but are not covered by your health insurance coverage. If you agree to receive these services, and they are later determined to not be eligible for reimbursement through your health plan policy, your signature on this form signifies your agreement to pay for them in full. **While you may choose to not obtain these services**, I want to reassure you that I will only recommend care that I believe will benefit your health.

Chiropractic services typically covered by health insurance policies include:

- Chiropractic manipulations to treat a clinical condition
- Treatment that has the potential to significantly improve a clinical condition
- Limited treatment of symptom flare-ups or exacerbations where a permanent condition exists.

Services that we expect to not be eligible for reimbursement through your plan's chiropractic benefit, and therefore will likely be your financial responsibility **should you elect to receive them**, are outlined below. Your financial responsibility is limited to services received during the treatment plan as defined below:

Treatment plan start date: ___________________ **Treatment plan end date:** ______________________

Note: The defined treatment plan can not be more than 12 weeks long

Non-Covered Service	Cost Per Visit*	Member Initials/Date
Exam(s)		
Manipulation		
X-ray(s)		
Therapies/Modalities (**Circle All Applicable Therapies**) Electrical Stimulation Acupuncture Other: _______________________ Ultrasound Exercise Education		
Durable Medical Equipment (**Circle All Applicable Products**) Braces Orthotics Ice Pack Other: ____		
Massage		
Other:		
Total:		

*Patient's billed amount may not exceed the provider's usual and customary amount

I believe these services will not be eligible for reimbursement through your health plan because (check one):

They are maintenance or elective care rather than treatment to improve a clinical condition
They are excluded from your chiropractic coverage, even when related to treatment to improve a clinical condition

Provider/Authorized Health Care Representative Signature: ____ **Date:** ___________________

I acknowledge that I am signing this statement voluntarily, and that it is not being signed after the services have already been provided. I have had ample opportunity to ask questions about my liability and the provider/staff has answered them to my satisfaction. **I understand that I have the right to refuse this care and that by signing this form I will be fully responsible for the total billed charge(s) related to non covered services.**

____ Date: ___________________

Patient's Name

____

Patient or Authorized Representative Signature

A copy of this signed form must be provided to the patient upon request