Patient Waiver for Non-Covered Services

B. Patient Name _____ Date: _____

Your insurance does not pay for all of your health care costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services.

Your physician believes that the following service(s), although not covered by your health insurance, are an important part of your chiropractic care and recommends that you receive these services as part of your current treatment plan. However, since the services listed here are not considered to be covered benefits under your health insurance, should you choose to receive these services; you will be personally responsible for the payment of such services. The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services.

The services recommended by your physician are listed below:

☐ Laser Therapy	$75.00
☐ Decompression	$100.00
☐ Ultrasound	$25.00
☐ Supply Item	$
☐ Diathermy	$25.00

The total cost for the services/items recommended by your physician is: $_____
I acknowledge that I have been informed in advance of receiving these services, that these services are not covered by my health insurance plan. I have chosen to receive these services and understand that I will be financially responsible for the charges indicated above.

Print Patient Name _____

Patient Signature _____

Provider Signature _____

Name of Parent or Legal Guardian (if applicable) _____

Signature of Parent or Legal Guardian (if applicable) _____

Date _____

This form must be signed by the patient or legal guardian PRIOR to receiving any non-covered services or items and must be maintained in the patient's health record.