COMPREHENSIVE HEALTH CLINICS **763-689-2462**
137 2ND AVE. SW, CAMBRIDGE, MN 55008 **FAX: 763-689-1688**

Non-Covered Services: Financial Disclosure Form

As your Doctor, I want to provide you with the best care possible. While your policy covers some 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 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.

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 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:
Chiropractic Treatment plan start date:_____ Treatment plan end date:_____
Note: The defined Chiropractic treatment plan cannot be more than 12 weeks long

Non-Covered Service	Cost of Visit*	Member please initial in box
Exam(s)	$20-$130	Initial: _____
Manipulation	$35-$65	
X-ray(s)	$30-$120	
Therapies/Modalities: Electric Simulation, Traction, Ultrasound, Exercise, Laser	$15	
Durable Medical Equipment: Braces, Ice packs, supplies	$5-$65	
Orthotics	$183-$215	
Supplements	$5-$110	
Acupuncture	$50-$130	
Medical procedures not deemed medically necessary	$30-$250	
Providers that are out of network for your plan		

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

INDIVIDUAL PROVIDER NAME	INDIVIDUAL NPI/UMPI	INDIVIDUAL PROVIDER SIGNATURE	DATE
GROUP PROVIDER NAME Comprehensive Health Clinics, PA	**GROUP NPI/UMPI** 1083785679	**AUTHORIZED HEALTHCARE REPRESENTATIVE SIGNATURE** Arthur K Volker, DC	**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 question 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 my signing this form I will be fully responsible for the total billed charge(s) related to non-covered services.**

Signature of Patient or Guarantor:	Date:

Print Patient Name:	Date of Birth