

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTICE OF NON-COVERAGE OR POSSIBLE NON-COVERAGE UNDER PRIVATE INSURANCE OR HEALTH PLAN**

NOTE: **If your private insurance carrier or health plan doesn't pay for services rendered, you are responsible and you agree to pay.** Your private insurance carrier or health plan does not pay for everything, even some care that you and/or your health care provider have good reason to think you need. Your carrier or plan does not pay for care that it determines to be "medically unnecessary" or "experimental and/or investigational," even if you and your health care provider deem the care to be necessary or beneficial and its effectiveness substantiated.

To the best of our information at this time (including information that may have been provided by your insurance carrier or health plan (if applicable), we expect and believe your private insurance carrier or health plan may not pay for the:

**Chiropractic Services** – consultations, exams, manipulations, rehab exercises, electric stimulation, traction and diagnostics.  
**Nutritional Services** – consultations, exams, supplements, diagnostics.

In addition to the procedures listed above, we may perform other procedures that we believe are covered by your insurance carrier or health plan, to the best of our information at this time (including information that may have been provided by your insurance carrier or health plan). Prior to the rendering of services, our office staff has shared with you to the best of our ability the information provided by your carrier or plan regarding coverage for these procedures.

HOWEVER, please be aware of the following:

- 1) Insurance carriers and health plans do not guarantee that they will pay for services even when they have verified coverage prior to the rendering of services. There are some situations in which a plan representative verifies coverage for a service but the company later refuses coverage.
- 2) Insurance carriers and health plans sometimes provide coverage for a particular service during a period of medical improvement, but at a point at which the carrier or plan determines medical improvement has ceased, the carrier or plan can determine the exact same services to be non-covered. This is often referred to as non-covered "maintenance care." Our office will exercise its best professional judgment by following substantiated treatment protocols. However, health care providers and insurance carriers and plans do not always agree about the exact point at which improvement is maximized for a patient. Therefore, you are aware that your insurance carrier or plan may cover certain services initially, but during the course of treatment may deem the same services to be non-covered. You agree to pay for all such services if your carrier or plan determines them to be non-covered.
- 3) Insurance carriers and health plans have the right to conduct patient records audits of doctors in their network. These audits often occur after treatment has concluded and/or the carrier or plan has paid the doctor. Following an audit, the insurance carrier or health plan in some cases may determine it should not have paid for certain services because the carrier or plan determines them to be non-covered. In these cases the carrier or plan may demand a refund from the doctor after the carrier or plan has paid the doctor. Please be advised that this office has made every effort to determine and share coverage information with you and to notify you when we in good faith believe a service or services will be non-covered. However, we cannot anticipate every action your carrier or plan may take in the future regarding a post-payment determination of non-coverage. Therefore, you are aware your carrier or plan may pay for certain services but may conduct a post-payment audit and demand a refund from this office. You agree to pay for all such services if your carrier or plan determines them to be non-covered.

In light of the above possible reasons for non-coverage for any and all services, we are providing you with the attached fee schedule for services that may or may not be covered by your carrier or health plan, so that you are fully apprised as to all potential out-of-pocket costs. Although we have made our best effort to identify the procedures we believe to be non-covered based on information your insurance carrier or health plan has given us, your carrier or plan may ultimately make a different determination as to coverage. You understand and agree to assume all financial responsibility for payment, regardless of your carrier's or plan's ultimate coverage decision for any specific procedure.

**WHAT YOU NEED TO DO NOW:**

- Read this notice so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the procedure listed above.

\_\_\_\_\_ **Option 1.** I want the procedure(s) listed above. You (health care provider) may ask to be paid now, but I also want my private insurance carrier or health plan to be billed for an official decision on payment, which is sent to me on an explanation of benefits. I understand that if my private insurance carrier or health plan does not pay, I am responsible for payment, but I can appeal to my private insurance carrier or health plan by following the directions on the explanation of benefits. If the insurance company does pay, you (health care provider) will refund any payments I made to you, less co-pays, coinsurance or deductibles.

\_\_\_\_\_ **Option 2.** I want the procedure listed above, but do not bill my private insurance carrier or health plan. You (health care provider) may ask to be paid now, because I am responsible for payment. I cannot appeal if my private insurance carrier or health plan is not billed.

\_\_\_\_\_ **Option 3.** I do not want the procedure listed above. I understand with this choice I am not responsible for payment and I cannot appeal to see if my private insurance carrier or health plan would pay.

Signing below means that I have received and understand this notice **prior to the services being rendered**. I also intend for this document to serve as a binding agreement between me and my health care provider that supersedes any document or policy to the contrary, in consideration of my health care provider's agreement to provide care. My health care provider will receive and retain a copy of this Notice.

\_\_\_\_\_  
Signature of Patient or Authorized  
Representative/Responsible Party

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date Signed

**OFFICE FEE SCHEDULE ATTACHED**

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date Signed