GERBER CHIROPRACTIC
763.757.8511
12265 CENTRAL AVE., NE
BLAINE, MN 55434

Non-Covered Services: Financial Disclosure Form

Your insurance may not pay for/cover everything, even some care that you or your health care provider have good reason to think you need. Services that **may not** be eligible for reimbursement through **your plan's chiropractic benefit**, and therefore may be your financial responsibility **should you elect to receive them**, are outlined below.

Service	**Estimated Cost:**
Exams - New Patient or Re-Exam	$40.00 - $110.00
CMT-Chiropractic Manipulative Treatments	$48.00 or $70.00
Therapies/Modalities Acupuncture Electrical stimulation Hydrobed Therapeutic Exercises Myofascial Release Ultrasound	$25.00 - $40.00 each
Durable Medical Equipment Braces, Orthotics, Ice Pack, Other	Varied costs not to exceed provider's usual and customary amount.

*Initial of representative presenting/explaining form to patient*_____

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 any and all non-covered services.**

Printed Patient Name_____

Patient signature must not pre-date the billed services by more than 12 weeks-per insurance regulations

Patient Signature_____***Date***_____

Updated Signature if Required by Insurance

*Patient Signature*_____*Date*_____

*Patient Signature*_____*Date*_____

*Patient Signature*_____*Date*_____

*Patient Signature*_____*Date*_____