Medical Assistance (MA) Member Consent for Non-Covered Services

Patient's Name_____Date_____

Chiropractic services that are covered by your health plan's chiropractic benefit and eligible for reimbursement include:

- **Manipulation of the spine to correct subluxation.**

Chiropractic services that are **NOT COVERED** by your health plan's chiropractic benefit and not eligible for reimbursement, are outlined below. These services will be your financial responsibility **should you elect to receive them**. Your financial responsibility is limited to services received during the treatment plan defined below.

NON-COVERED SERVICE	Cost Per Visit	Patient Initials/Date
X-ray(s) (MA covers 1 set per yr.)	**$45 per view**	
Therapies/Modalities : Ultrasound Electrical Stimulation Exercise Education Massage/Trigger Point	**$10 per therapy**	
Durable Medical Equipment/Supplies (Circle All Applicable) **Braces Orthotics Ice Pack Topical Analgesic Other**:_____	**Prices marked on products**	

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

I acknowledge that I am signing this statement voluntarily. I have had the 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. I acknowledge that I am fully aware that the services listed above are not covered by my health care plan and that I will be fully responsible for the total billed charge(s) related to the **Non-Covered Services.**

_____

Patients or Guardian Signature Date