Silver View Chiropractic Center

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

Patient's Name_____DOB: _____Date_____

Chiropractic services that are **NOT COVERED** by Medicaid or insurance plans administered through Medicaid are listed below. I have initialed the boxes below and understand, any charges that my insurance company does NOT cover, I will be responsible for.

NON-COVERED SERVICE	Cost Per Visit	Patient Initials
EXAM (covers 1 per yr.) I am aware that if I have seen another chiropractor in the same year that I will be responsible for the exam charge.	**$35** (if you have seen another chiropractor in the same year)	
Spinal Manipulation, that is performed and deemed NOT medically necessary, I am aware that I will be responsible for this charge.	**$30 1-2 regions** **$40 3-4 regions**	
Therapies/Modalities : EMS, Manual Massage/Trigger Point, Ultrasound I am aware that I will be responsible for this charge.	**$15 per therapy**	
Durable Medical Equipment/Supplies (Circle All Applicable) **Supplements, Braces, Orthotics/Heel Lifts, Ice/Heat Packs, Topical Gels, Tens Unit, Etc.** I am aware that I will be responsible for this charge.	**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.**

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Patients or Guardian Signature Date

Revised 12/29/22