

ADVANCE NOTICE OF NON-COVERED SERVICES

OUR OFFICE POLICY FOR MEDICARE PATIENTS

Medicare will only pay for services that it determines to be "Reasonable and Necessary". If Medicare determines that a particular service is not "Reasonable and Necessary" under the Medicare program standards, Medicare will deny payment for that service. (Section 1862(a)(1) of the Medicare law).

In accordance with the current Medicare Regulations you are required to pay a yearly deductible of \$ _____ toward your medical expenses, effective January 1st of each year.

1. Chiropractic is covered under the Medicare program as a LIMITED service.
2. Medicare pays for **MANUAL MANIPULATION OF THE SPINE ONLY**.
3. X-Rays are required by Medicare and **are NOT a covered Chiropractic benefit. You must pay for your own.** (X-Ray date must be within 3 months for acute conditions, and 12 months for chronic conditions).
4. The following services are **not covered** by Medicare. **You will be responsible for payment of any of these treatments or services:**
Office calls, X-Rays, Physical Therapy, Nutritional Supplements, Physical Examinations, Diagnostic Evaluations, Consultants, Diagnostic Tests, Laboratory Tests, Orthotic Supports/Braces or Maintenance Care.
5. An examination is **required** by the doctor before any treatment can be rendered. This examination is **NOT a covered chiropractic benefit of Medicare and must be paid by you.**
6. Medicare does not pay for like services by more than one doctor of the same specialty.
7. Medicare does not pay for more than one office visit per day.
In most cases, Medicare will consider only 12 office visits per year as "Medically Necessary", and will pay for 80% of the "allowable treatment charges" for Chiropractic care.

I understand the Medicare Policy of this office, as required by Medicare, and agree to be personally responsible for all non-covered Chiropractic care and treatment. I agree that the charges will be personally paid for by me according to the credit policy of this office.

I hereby authorize Dr. _____ to render whatever services deemed necessary for my care, and agree to assume all financial obligations incurred for my care.

I also AUTHORIZE any holder of medical information about me, to release it to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare Claim.

Patient's name _____ Date _____
(PATIENT'S NAME EXACTLY AS SHOWN ON MEDICARE CARD)

Patient's signature _____ Witness _____

Signature of Patient's Representative _____ Date Signed _____

Relationship of Representative _____

Name of Rendering Doctor: DR. MARK CAMPBELL, D.C. PIN # DC19399

Clinic or Office Name: CHIROPRACTIC HEALTH

Address: 206 S. PLACENTIA AVE., PLACENTIA, CA 92821