BAIRD CHIROPRACTIC CENTER, INC

PATIENT BILLING ACKNOWLEDGEMENT FORM

Under your health plan, you are financially responsible for co-payments, co-insurance and/or deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health insurance plan including care determined to be elective or maintenance.

Maintenance/Elective Care

Maintenance/Elective Care is treatment that does not significantly improve a clinical condition. While being treated for a chronic condition, you may elect to receive care beyond that which is determined to be medically necessary, as determined by your health insurance plan. You may also choose to receive maintenance care once maximum benefit from treatment has been reached.

If during the course of Maintenance/Elective Care, you develop a new condition or a previous condition becomes significantly worse, care may no longer be considered "maintenance/elective" and may then be covered by your health insurance plan. Your provider must submit a request for insurance coverage.

These treatments or products are typically covered only if medically necessary: **Initial**_____

- Spinal Manipulation - $46.00/$67.00
- Therapy - $25.00/$28.00
- Evaluation/Exam- $40.00 - $260.00
- Cryotherapy/Moist Heat Packs
- Other - _____

These treatments or products are typically NOT covered and are optional according to your health insurance plan:

- Maintenance (except BCBS NC State Plan) - $55.00
- Acupuncture - $66.50, plus $.50 per pack of needles
- Spinal Decompression (20 visits) - $2,923.76
- Chiropractic Supplies (vitamins, pillows, orthotics, other DMI)
- Other - _____ **Initial**_____

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I, _____, acknowledge that I have been told in advance by my provider that the services or products listed above are, or are not covered by my health insurance provider. I agree to pay for the maintenance/elective/non-covered services or products not covered by my health insurance provider.

Patient Signature Date

Provider Signature

This form is valid for one year from the date it is signed.