Patient Billing Acknowledgement Form
Non-Covered Services**

Under your health plan, you are financially responsible for co-payments, co-insurance and 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 plan contract. For example, this may include items such as supplies, vitamins, or durable medical equipment.

The services or products listed below are not covered according to your health plan. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay for the listed services or products.

** **Not for use in New Jersey**

PROVIDER

Services to be provided:

☐ Supply _____ ☐ DME _____

☒ Modalities/Procedures 97014 - EMS / 97039 - Laser / 97214 - Massage ☐ Other _____

Time frame from _____ through _____

Schedule/details _____

Provider Signature: _____

PATIENT

I _____, acknowledge that I have been told
Patient Name – Printed or Typed
in advance by my provider that the services/products listed above are not covered by my Health Plan. I agree to pay for these non-covered services.

Patient/Guardian Signature _____ Date _____

Patient Billing Acknowledgement Form
Maintenance/Elective Care**

Under your health plan, you are financially responsible for co-payments, co-insurance or deductibles for covered services. You are also financially responsible for all non-covered services, including care determined to be elective or maintenance.

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. 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 plan. Your provider must submit a request for insurance coverage.

** **Not for use in New Jersey**

PROVIDER

Services to be provided are listed below:

☐ Chiropractic Manipulative Therapy _____ ☐ In-Home Care _____

☒ Modalities/Procedures S8990 - Maintenance ☐ Other _____

Time frame from _____ through _____

Schedule/details _____

Provider Signature: _____

PATIENT

I _____, acknowledge that I have been told
Patient Name – Printed or Typed
in advance by my provider that the services/products listed above are not covered by my Health Plan. I agree to pay for these non-covered services.

Patient/Guardian Signature Date

_____ _____