Health Goals Chiropractic Center, Inc.

Patient Acknowledgement of Non- Covered Services and Products

Patient Name: _____

Your health insurance plan requires you to be responsible for co-payments, co-insurance and deductibles for covered services and products as well as these services/products that exceed certain benefit limits. You are also financially responsible for all non-covered services and products.

Your health insurance plan may not cover the product type or service noted below. Your acknowledgement indicates that you have been advised of this information and that you agree to pay the office's charge.

Service/Product	Reason Insurance May Not Pay:	Estimated Cost
Examinations/Evaluations	**Excluded Service**	**$150.00 / $75.00**
Supplies	**Excluded Service**	**$10.00 - $200.00**
Spinal Manipulations	**Excluded Service**	**$ 60.00**
Manipulations Exceeded ForCondition	**Medical Necessity**	**$ 60.00**
Massage	**Excluded Service**	**$ 30.00 up**
Exercise/Personal Training	**Excludes Service**	**$ 30.00 up**

Patient Acknowledgement:

I _____acknowledge that I have been told in advance by this office that my health insurance plan does not cover supplies or other services listed above. I agree to pay for this product at the time of service.

Patients Signature:	**Date:**