

**ERICKSON CLINIC OF CHIROPRACTIC**

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MINIMIZING PAIN  
MAXIMIZING FUNCTION

**Non-Covered Services Acknowledgement Form**

Patients are responsible for co-payments, percentages, and deductibles for covered services as well as those services that exceed benefit limits. You are also responsible for all non-covered services as defined by your health plan contract or redefined by a third-party processor.

We make every effort to inform our patients of their insurance benefits / limitations. A quotation of benefits by your insurance company, is not a guarantee of payment. Insurance coverage is based on medical necessity as defined by your insurance company. For example, visit frequency (gaps in care) can be an indication that coverage falls outside the parameters covered by your plan.

Dr. Erickson believes that the following service(s), although not covered by your health insurance, are an important part of your chiropractic care and recommends that you receive these services as part of your current treatment plan. Services may include the following:

- Limited coverage / minimal services, such as therapies or services not authorized by your primary care physician
- Certain services not covered by your insurance (supports, supplements, pillows , x-ray interpretation "Triad Radiology", and often multiple x-ray views are limited by insurance coverage)
- Rehabilitative, maintenance, supportive, wellness, elective care, as needed care (PRN).

With my signature below, I indicate that the Erickson Clinic has notified me in advance that, the services / products listed above are not covered by my health plan. I agree to be personally and fully responsible for the payment of these products / services provided by the Erickson Clinic.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_