FULCRUM HEALTH

Provider Name: _____

Provider Address: _____

Provider Phone: _____

Non-Covered Services: Financial Disclosure Form (Commercial)

Your health care coverage may not cover all items or services requested by you or your provider. As part of your treatment plan, your provider will discuss the coverage and costs of any non-covered items/services, including those no longer considered medically necessary (also known as Maintenance/Wellness Care). Your health care provider may charge you for these non-covered items/services should you choose to accept them. Before signing this form read this notice and the instructions so you can make an informed choice about your care and ask your health care provider any questions you may have.

Additionally, you may request to pay out-of-pocket (self-pay) and withhold claims submission to your insurance company entirely or for specific dates of service. If that is the case, you may list relevant dates of service and not fill out the chart below.
Dates of service to exclude from claims submission to insurance: _____ or _____I wish to abstain from claims submission to my health care plan for all dates of service covered under this agreement. (Initial)

If you are not opting out of insurance claims submission, the following information is required. All fields must be entered completely, including dates, costs and reason why services are not covered. The patient must acknowledge each non-covered line with their initials to be considered valid.

Treatment Start Date: _____ *Treatment End Date: _____

***Note: A new Financial Disclosure Form must be reviewed and signed with the patient every 12 weeks for care not covered under their plan, for elective care after a new acute episode that has achieved maximum therapeutic benefit (even if it is within a previous 12-week period) or for exclusion from insurance claims submission.** Form must be signed prior to rendering non-covered items/services. Failure to fill out this form in its entirety will make the form invalid and charges will be provider liable.

Non-Covered Chiropractic Service	Reason Item/Service is not covered	Cost per Visit	Patient Initials
Exam(s)			
Manipulation (for maintenance care or wellness)			
X-Ray(s)			
Therapies/Modalities (circle all that apply) Electric Stimulation Acupuncture Ultrasound Exercise Education Other_____			
Durable Medical Equipment (circle all that apply) Braces Orthotics Ice pack Other: _____			
Massage			
Other (specific)			
	TOTAL COST:		

I, _____ *(patient's name)* understand the above items/services are not expected to be covered, have been denied by my health plan, or are not being billed to insurance at all. I agree to accept the services/dates of service(s) listed above and agree to pay the charges. I acknowledge that I am signing this statement voluntarily. I understand that by signing this form, I will be fully responsible for the total billed charge(s) related to non-covered services or exemption of claims submission to my insurance company (self-pay).

Patient/Authorized Representative Signature: _____Date: _____

Provider/Clinic Administrator Signature: _____ Date: _____

This form is based on requirements detailed in Fulcrum's Noncovered Services Policy NM007, available on ChiroCare.com xxxxx