John Doe Chiropractic & Wellness Center
Dr. John Doe
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Any Town, HT 12345
(123) 123-4567
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Patient Acknowledgement Form for Non-Covered Services

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 those services/products that exceed certain benefit limits. You are also financially responsible for all non-covered services and products.

Your health insurance plan either does not cover the product or type of service, has determined this procedure/service is not medically necessary, has created policy to identify it as experimental or investigational, or the allowed fee is below the purchase price for the item. These items are listed below.

PROCEDURE / ITEM / SERVICE DESCRIPTION	CPT CODE	ESTIMATED BILLED PROFESSIONAL CHARGE

Patient Acknowledgement:

I _____ acknowledge that I am voluntarily signing this statement, and that it is not being signed under duress or after the services have already been provided. I understand that by signing this form, I will be fully responsible for the total billed charge(s) for any procedure/item/service listed above that is denied as non-covered by my healthplan and will pay the provider as charged. I also understand that it is my choice to have the services provided at a future date and time by this provider.

Patient Signature:_____ **Date:** _____

OFFICE USE

NOTE: Prior to implementing, be sure that the Payer does not require the clinic to use the payer's Advance Member Notice (AMN) form. This acknowledgement form is not to be used in place of a HIPAA Restriction to Disclose PHI to a Healthplan form. If the patient is insured and opting not to use their health insurance, please implement a HIPAA Restriction to Disclose PHI to Health plan form and a Good Faith Estimate form if applicable. Provide a copy to the patient and place a copy in the patient's medical record.