

Crossroads Chiropractic Clinic
251 Co Rd 120, St. Cloud, MN 56303
(320)252-3711

Non-Covered Services: Financial Disclosure Form

As your Doctors of Chiropractic, we want to provide you with the best care possible. While your policy covers some chiropractic services, there are others that our Doctors may recommend but are not covered by your health insurance coverage. If you agree to receive these services, and they are later determined to not be eligible for reimbursement through your health care plan policy, your signature on this form signifies your agreement to pay for them in full. While you may choose to not obtain these services, we reassure you that our doctors will only recommend care they believe will benefit your health.

Services that we expect to NOT be eligible for reimbursement through your plan's benefits, and therefore will likely be your financial responsibility should you elect to receive them, are outlined below:

Non-Covered Services	Cost Per Visit
Medicare Exam	\$50.00
Electrical Stimulation	\$15.00
Ultrasound Therapy	\$15.00
Acupuncture	\$50.00
Medical Equipment or CBD products	Price Varies

I believe these services will not be eligible for reimbursement through your health plan because:

- They are maintenance or elective care rather than treatment to improve a clinical condition.
- OR**
- They are excluded from your chiropractic coverage, even when related to treatment to improve a clinical condition.

I acknowledge that I am signing this statement voluntarily and that it is not being signed after the services have already been provided. I have had ample opportunity to ask questions about my liability and other covered treatment alternatives. I understand that I have the right to refuse this care and that by signing this form, I will be fully responsible for the total billed charge(s) related to non-covered services.

Patient's Name: _____

Patient's Signature: _____

Date: _____