

Langford

Chiropractic Clinic

Dr. Anne Langford

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Acknowledgement of Financial Responsibility

Non-Covered Services Annual Disclosure Form

As your Doctor of Chiropractic, I want to provide you with the best possible care. There are services that I feel are in your best interest for the treatment of your condition and maintenance of good health that may not be covered by your health insurance coverage. You will be expected to pay for those services in full. Let me reassure you that I will only provide care that I feel is necessary.

Covered services traditionally include:

- Treatment that has the potential to significantly improve a clinical condition.
- Limited treatment of symptom flare-ups or exacerbations where a permanent condition exists.

Services not covered include:

- ✓ Some Diagnostic Services
- ✓ Some Therapeutic Services
- ✓ Some Durable Medical Products (including braces, ice packs, etc.)
- ✓ Maintenance Care aka Elective Care.

I acknowledge that I am signing this statement voluntarily, and that it is not being signed 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) related to non-covered services.

Patient's Signature: _____

Date: _____

Acknowledgement of Fin Resp