



BOURREE CHIROPRACTIC AND MASSAGE
 KIRKLAND PROFESSIONAL CENTER
 433 STATE STREET SUITE 6
 KIRKLAND, WA 98033

INSURANCE NON-COVERED
SERVICE DISCLOSURE AND AGREEMENT

Name of Patient: _____

Name of Provider: David Bourree D.C. DACS

Type of Service:

1. Exams 99201-99205 \$60.00--\$285.00
2. X-rays 72010-72220 \$25.00--\$260.00
3. Re-Exams/Reports of Findings 99211-99215 \$40.00--\$195.00
4. Adjustments 98940-98942 \$50.00--\$78.00
5. Extremity Adjustments 98943 \$35.00
6. Intersegmental Traction, Ice 97012, 97010 \$15.00--\$45.00
7. Chiropractic Supplies, i.e., pillows, inserts, ice packs, etc. \$3.50--\$90.00
8. Exercises and Rehabilitation 97110, 97150, 97112, 97530 \$15.00--\$55.00

Proposed Dates or Range of Dates of Services: See Chiropractic or Rehabilitation Care Schedule

Potential Reasons for Non-covered Status:

- ◆ The service is or may be deemed investigational or experimental under the carrier's internal guidelines.
- ◆ The service is considered, or may be deemed, not medically necessary under the carrier's internal care or cost management guidelines.
- ◆ The service is not or may not be actually covered under the plan to which the above patient is subscribed.
- ◆ The service is not or may be deemed as not provided in accordance with the Provider's Agreement with the carrier or other requirements of the carrier's or managed care entity's internal guidelines.

The carrier authorizes the provider to charge the patient for the above services so long as this disclosure is made and signed by the patient prior to the services being provided.

Patient Financial Responsibility:

The undersigned patient acknowledges that the Non-Covered status of the proposed service(s) has been explained, and that a certain portion of the patient's care may not be covered by or has not been authorized by the patient's insurance plan. The undersigned acknowledges that if any portion of the care provided is not, or may not be, covered by insurance, then the undersigned shall be responsible for payment, and shall make the necessary financial arrangements with the healthcare provider to pay for these services.

Print Name: _____ Signature: _____

Date: _____ Insurance Plan: _____