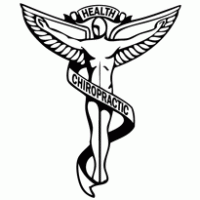
CAPITAL CHIROPRACTIC CENTER, P.C.

**Patient Billing Acknowledgement Form**

**MAINTENANCE / ELECTIVE CARE**

Under your health plan, you are financially responsible for copayments, co-insurance or deductibles for covered services. You are also financially responsible for all non-covered services, including care determined to be elective or maintenance.

Maintenance / Elective Care is treatment that does not significantly improve a clinical condition. While being treated for a chronic condition, you may elect to receive care beyond that which is determined to be medically necessary. You may also choose to receive maintenance care once maximum benefit from treatment has been reached.

If, during the course of Maintenance / Elective Care, you develop a new condition or a previous condition becomes significantly worse, care may no longer be considered Maintenance / Elective and may then be covered by your health plan. Your provider must submit a request for insurance coverage.

**PROVIDER**

*Services to be provided:*  􀂈 Manipulation 􀂈 Manual Therapy 􀂈 Physical Therapy Modalities 􀂈 Other

*Time Frame*: From: Through:

*Schedule / Details:*

*Provider Signature:*

**PATIENT**

I, , acknowledge that I have been told in advance by my provider that the services listed above are not covered by my Health Plan, and that they meet the above definition of non-covered Maintenance / Elective Care. I agree to pay for these Maintenance / Elective services.

Patient Signature Date

Parent / Guardian Signature Date