ACUPUNCTURE CLINIC of MISSOULA

PATIENT WAIVER FOR NON-COVERED SERVICES

Patient's Name: ____ Date: ___________________

Your insurance does not pay for all of your healthcare costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services.

Should you choose to receive these services, you will be personally responsible for the payment of such services**. This waiver includes Insurance, Self-Pay, and Telemedicine Appointments.**

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services.

Services Often Not Covered by Your Insurance Include:

CPT Code	Supply or Service	Cost
99201 99202 99203	Initial Patient Evaluation / exam	$ 50-90 *
99211 99212 99213	Existing patient re-evaluation / exam	$ 30-50 *
97139	Unlisted Therapy (Cupping, Moxa, other)	$15-30 *

*** You are always entitled, by law, to a copy of the documentation generated by our office about your visit and treatment.**

**Other Non-Billable Service: Herbal Consult 15-60 Minutes $30-90

By signing this notice you agree to take financial responsibility for the cost of the supplies and services listed above should your insurance company deny coverage. If the patient is self-pay (not billing insurance) charges incurred are due at the time or service.

Patient Signature ____ Date: ____________

Signature of Parent or Legal Guardian (if applicable): ____

Printed Name of Parent or Legal Guardian (if applicable) : ____________________________________

This form must be signed by the patient or legal guardian PRIOR to receiving any non-covered services or items and *must be maintained in the patient's medical record.*