Name of Practice

Election Not to File Health Insurance Claims

(*This form is only for non-PI Patients*.)

The chiropractor(s) at this practice are participating (“in-network”) providers for your health benefit plan. As participating providers, we are required to file claims for reimbursement with your plan for all *covered* services provided to you UNLESS you instruct us in writing not to file.

You have indicated that rather than using your own health insurance, you wish to pay this office directly for services we provide to you *relating to this episode of care* (until the physician determined you have reached maximum medical improvement (MMI)).

To help you make an informed decision, please carefully review the following information.

**If you elect NOT to file claims on your health insurance:**

1. The practice will rely on your decision not to file your claims to your healthcare plan and you will be responsible *for the payment of all charges for all services provided to you*.
2. The cost of your treatment will be billed to you at the practice’s usual rates rather than the discounted rates that routinely apply to services covered by your health benefit plan.
3. None of the charges for your treatment will be applied towards satisfying the annual deductibles associated with your health benefit plan.
4. If you elect not to file claims to your healthcare plan, for treatment related to this episode of care, your decision is irrevocable.

**If you elect TO file claims on your health insurance:**

1. Your health insurance should pay the cost of *covered* services provided to you, except for copayments, co-insurance and/or deductibles, which you will be expected to pay at the time services are rendered.

1. You will be responsible for paying the cost of any *non-covered* services you have elected to receive (via your signature on this practice’s Non-Covered Services Waiver), and unless a payment plan has been established, payment for those services will be due at the time services are rendered.

**Election not to file health insurance claims:**

1. By my signature below, I attest that I have read and understand the above information regarding the options available to me and have been given an opportunity to ask questions, and to have those questions answered.
2. I understand that the practice is relying on my decision not to file health insurance claims, *related to this episode of care* is irrevocable.

I hereby instruct the practice not to file claims to my health care plan for services related to this episode of care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed** Name of Patient **Printed** Practice Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Signature of Practice Representative

(or parent/legal guardian, as applicable)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: Date:

A complete copy of this executed agreement

must be maintained in the patient’s health care record, and a copy must be provided to the patient.