

MEDICARE PAYMENT POLICY

The purpose of this form is to help you make an informed choice about whether or not to want to receive, and be financially responsible for services and/or items not covered by your Medicare insurance.

Medicare covers 80% of the cost of 12 chiropractic manipulations/year only. That leaves you a co-pay of 20% for that service. In addition, you will have a deductible that will have to be met before any coverage begins and you are responsible beyond the 12 manipulations/year.

Medicare does not cover any other services performed or items purchased in this office. You, and/or your co-insurance, if you so choose, bear the full financial responsibility for any service/item not covered by your Medicare insurance.

Items/services not covered by Medicare:

1. Initial Examination
2. Use of physical therapy modalities: including but not limited to:
 - Interferential therapy
 - Hot or cold packs
 - EMS (various forms of electric muscle stimulation)
 - Ultra-sound
 - Trigger point therapy
3. Instructional time: including, but not limited to:
 - X-ray interpretation and/or review
 - Home based exercises
 - Home instructions
 - Nutritional advice
4. Items: including, but not limited to:
 - Low back supports
 - Hot or cold packs
 - Other braces, supports, orthotics
 - Nutritional supplements

The cost of the initial examination, and subsequent exams at one year intervals, is \$90.00; if you pay at the time of service, \$95.00, if we have to bill you.

As a courtesy to our senior patients we will discount all physical therapy modalities and charge for only one additional service performed per visit: for a cost to you of **\$10.00/ov in addition to your co-pay.**

Any item, orthotic, nutritional supplement, etc. will be charged at the per item cost, plus sales tax.

Option 1: ____ **Yes:** I want to receive the services and/or items deemed necessary for my health care treatment in this office. I understand Medicare will cover 80% of the 12 manipulations/year only, after a deductible, leaving me financially responsible to Dr. Peter May, DC for my 20% co-pay and any other services performed and/or items purchased above and beyond the 12 manipulations/year. _____ Date: _____

Option 2: ____ **NO:** I have decided NOT to receive any service or item not covered by Medicare. I understand Dr. May will not accept me as a patient without first performing an examination. _____ Date: _____