Unbroken Body LLC
1280 Diamond Way
Concord CA 94520

Advance Notice of
Patient Responsibility for Non-Coverage

Cost per visit:

- 0 to 17 years of age and 65 to 79 years of age **$65**
- 18 to 64 years of age **$85**
- Over 80 - non-covered costs are waived **Co-pay**

Visit length:

- Exam with treatment 45 minutes
- Treatment alone 20 minutes

Discounts available:

- Full time K1 through K12 teachers
- Junior college professors
- Financially single parents

We accept cash, check, credit card and all insurances. Payment/Co-payment is expected on the day that services are rendered. If you choose to pay for all of your treatment in full at time of service, any overpayment will be refunded within 3 business days or credited to your account for future care. Insufficient funds fees, non payable check fees are the responsibility of the payer.

Insurance coverage of Chiropractic services is a limited benefit. The coverage is limited to manual manipulation for the treatment of subluxation, other treatments are either *not Medically Necessary* or *non-covered*. Insurance may reduce some or all of the cost of your visit. Insurance may require a referral, and is the patient's responsibility to request from their primary provider.

Contracting health care professionals are prohibited from charging patients for any service that is determined by the insurance to be *not Medically Necessary* or *non-covered*, unless the patient specifically agrees in advance of the service to be financially responsible.
Note, If your insurance does not pay the services listed below, you may have to pay.

Office Visits (history and physical)	Active Release	Deep soft tissue adjustment
Rapid Release	Massage	Physiotherapy
IASTM	Cupping	Supplies

Referral Services

Traction	Orthopedic devices	Physical culture
Nutritional supplements	Diagnostic studies (EKGs)	X-rays

I understand that a contracted provider may not charge me for a service determined to be *not Medically Necessary* or *non-covered* unless I have specifically agreed to pay for it. I also understand that the provider and/or I may appeal any determination that a service is *not Medically Necessary* or *non-covered* by filing a grievance or appeal with insurance. I understand that I am financially responsible for payment to the provider, even though the service may not be shown on my Explanation of Benefits (EOB) as my financial responsibility.

By signing below, I agree to pay Unbroken Body LLC., up to the maximum listed above, for those services that may be determined as *not Medically Necessary* or otherwise *not a covered benefit* or excluded from compensation from a third party.

Patient/Legal Guardian Signature