NOTICE OF MEDICARE COVERAGE
FOR CHIROPRACTIC CARE

It is challenging for the chiropractor, who provides services based on a holistic paradigm, to predict when Medicare will allow treatment and when it will deny coverage. You may present with symptoms resulting from life activities and or conditions or aggravations of conditions that are considered worthy of "active treatment" and are reimbursable. Please be aware, however, that your Medicare coverage of chiropractic care is limited. It does not pay for all services. It will only pay for your chiropractic adjustment when it meets Medicare's specific rules.

Catherine Englehart, DC is not a Medicare participating provider and as such she collects payment at time of service. The office staff at Roosevelt Chiropractic will bill Medicare for you and Medicare will reimburse you if coverage is allowed.
Please read the following about Medicare's policies regarding services:

NON COVERED
All services other than chiropractic adjustments:

- Office visits for evaluation and/or management
- Physiotherapy such as myofascial therapy/soft tissue massage/exercise instruction
- X-rays/labs/supplies

Various Chiropractic Treatments:

- Non spinal manipulation of shoulder/arm/leg/etc
- Maintenance Care-your condition is stable and no longer improving
- Wellness Care-to promote better health

ALWAYS COVERED
A Medicare COVERED service is for when you are injured or when you are in pain due to a bad spinal condition. Medicare pays for your rehabilitation as long as you are improving. This phase of care is called "active treatment". It will be shown on your Medicare claim form and payment reports with your service code. For example, "98940-AT"

PERHAPS COVERED
Your Chiropractic Adjustment must be clinically needed to correct a problem of the spine, according to Medicare rules. If Medicare determines that your condition is not "Medically Necessary" they will not pay.

MY FINANCIAL RESPONSIBILITY

I have received the above Medicare information. I understand that I am personally financially responsible for all services and agree to pay at time of service.

X_____

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Signature Date

MY AUTHORIZATION

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

X_____

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Signature Date