MEDFORD
Complete Care Health Centers
3132 State Street, STE. 110
Medford, OR 97504
(541) 830-4325
(541) 826-2620

EAGLE POINT
Complete Care Health Centers
1296 South Shasta Ave.
Eagle Point, OR 97524
(541) 830-4325
(541) 826-2620

Non-Covered Service Waiver

I ______________________________, DOB ___________ understand that the services I will be receiving may not be considered eligible for benefits (services may be determined not medically necessary, non-covered, or investigational) by my health insurance provider. I understand that my health insurance coverage has certain restrictions and limitations, such as prior authorization requirements and non-covered service guidelines. Complete Care will attempt to obtain authorization on your behalf. In the event it is denied, and there is no payment issued by the insurance, I understand I will be responsible for the balance.

By signing this form, I understand that I am agreeing in advance to receive these specific services and to pay for the services indicated below if my insurer denies payment because the services are not covered by my health insurance plan.

Service	Code	Price
[ ] Chiropractic Manipulation	98940 // 98941 // 98943	$50.00
[ ] Massage Therapy 30 Minutes [ ] Massage Therapy 45 Minutes [ ] Massage Therapy 60 Minutes [ ] Massage Therapy 90 Minutes [ ] Massage Therapy 120 Minutes	97124 or 97140	$50.00 $65.00 $75.00 $105.00 $140.00
[ ] Combo Ultrasound Therapy [ ] Ultrasound Therapy [ ] Cold Laser Therapy [ ] E Stem Therapy	97032 97035 97039 97014	$15.00 $15.00 $15.00 $15.00
[ ] X-Ray Cervical 2-3 view [ ] 4 or more view Cervical	72040 72050	$87.00 $117.00
[ ] X-Ray Thoracic 2 view	72070	$73.00
[ ] X-Ray Lumbar 2-3 view	72100	$88.00
[ ] X-Ray Shoulder 2 views minimum	73030	$76.00
[ ] X-Ray Knee 1-2 view	73560	$76.00
[ ] X-Ray Hip 1 view [ ] Hip 2-3 view	73501 73502	$73.00 $105.00
[ ] Office visit/ Re-eval	99202-99204 99212-99214	$70.00
[ ] Other ________________	_____________	$_________________

_______________________________________ Signature of patient or representative

_______________________ Date of Service