MICHAEL H. ROGERS, D.C., D.A.B.C.O.
CHIROPRACTIC PHYSICIAN
475 School Street – Suite 7
Marshfield, MA 02050
781-826-6311 Fax 781-826-6634

Date:___________________

Dear Patient:

Please be advised that your Insurance provider may or may not cover Modalities (Therapies). Our staff makes every effort to obtain this information, but it is your responsibility to know what your insurance plan does and does not cover. If your insurance does not cover modalities (therapies such as ultrasound, massage therapy, electrical stimulation etc.), you will be responsible for payment of the treatment.

Please **initial** ***one*** of the following statements and sign at the bottom to acknowledge your responsibility as a patient.

_____ I **Do** want to receive therapy recommended by Dr. Rogers, **even if my insurance does not cover it,** and acknowledge that I will be responsible for payment of the therapy.

_____ I **Do Not** want to receive therapy that it is not covered by my insurance.
*****I acknowledge that it is my responsibility to decline any therapy not covered by my insurance or I will be responsible for payment of the non-covered therapy that I receive.***

____
Patient Signature

This form will be kept in your file and will be applicable to all future treatment.