Chiropractic Applied Kinesiology Vitamins Herbs
Homeopathy Health Education Classes

BOZEMAN WELLNESS CENTER

Refusal to Allow Submission of Billing to Insurance

Dr. Philip Cameron , DC (NPI# 1053417287) is notifying the following listed patient of the information contained in this document.
I, _____ whose Medicare number is_____, desire to obtain professional Chiropractic and Kinesiology services from the doctor.

The reason Medicare is NOT expected to pay for the professional services of Dr. Philip Cameron, DC is that he is not enrolled in the Medicare system as a provider of services, and therefore payment for all of these services is denied by law.

I desire to receive professional services from this doctor, and by my own free will agree NOT to submit a claim to Medicare or to ask Dr. Philip Cameron, DC to submit a claim to Medicare. I also understand that those insurance companies that pay for health care benefits only on condition that Medicare first be billed will not pay any health insurance. In order to avoid problems and to be consistent with what is stated here, I also refuse to allow the submission of bills to other health insurance companies that base their payment upon Medicare first being billed.

I understand that Medicare payment will NOT be made for any items or services furnished by Dr. Philip Cameron, DC that would have otherwise been covered by Medicare if there was not a private contract and a proper Medicare claim had been submitted. I understand that Medicare limits do not apply to what Dr. Philip Cameron, DC may charge for items or services furnished. Therefore, I accept full responsibility for payment of charges for all services furnished by the doctor.

I understand and enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

I understand that I have the right to change my mind and decision at any time, and further agree that if I decide in the future to have professional services by this doctor and/or their office billed to Medicare, I will first inform the doctor/office of my decision in writing, which will only be effective upon the doctor receiving my signed written statement with this intention and simultaneously this intention will operate as an immediate withdrawal from care from the doctor, their office, and their professional services.

I also understand that my signature acknowledges that I have read, agree with what is written, of my own free will give these instructions, understand this document, and will promptly receive a copy of this notice after signing this notice.

Patients Signature:_____Date:_____

Patients Legal Representative Signature:_____Date:_____

Provider's Signature:_____Date:_____

Witness:_____Date:_____