Bruns Chiropractic Clinic
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Mainecare/Medicaid Explanation of Chiropractic Coverage

Our office will bill Mainecare/Medicaid directly for services rendered in this office that Mainecare covers as explained below. Mainecare requires a primary care referral for all patients 18 or over.

Mainecare will only pay for services it determines to be medically necessary and only for treatment of the spine. Treatment of any other body areas other than the spine is not covered under the Medicaid program.

Mainecare will only cover the following services:

1. Spinal X-rays (up to 2 per year)
2. Chiropractic manipulation of the spine (up to 12 visits per year)
3. Additional treatment beyond the 12 visit limit may be allowed with approval from both your primary care physician and from the Mainecare pre-authorization department.

Mainecare patients will be responsible for the following services and fees which are not covered by Maine Medicaid.
For all new patients and existing patients Mainecare requires an initial examination to support medical necessity, which they do not cover. If treatment extends beyond 6 months they require a re-examination to further support the need for prolonged treatment.

1. May have a co-pay of $2 for exam and $1 per visit depending on Mainecare coverage.
2. Therapy such as EMS or Ultrasound, which is $25.00 per modality, is not covered.
3. Extremity adjustment, which is $40.00, is not covered.
4. Myofascial Release, which is $45.00, is not covered.
5. Acupuncture, which is $80.00, is not covered.

I have read and understand my Chiropractic coverage under the Maine Medicaid program and I understand that any balance not covered by my insurance will be my responsibility and I agree to pay said balance in full.

Payment Agreement

☐ I am unable to pay the outstanding balance in full, I would like to enter into a partial payment agreement with Bruns Chiropractic Clinic.

I agree to make: ☐ Weekly ☐ Monthly payments of $ ____________ until my balance is paid in full.

I agree to pay at the time of service: ☐

Please discuss any questions with a staff member you may have prior to signing below.

Patient/ Guardian signature:____ **Date:**_______________

Patient name(printed):____