



DR. LAURA E. HARRINGTON  
Liverpool Chiropractic & Wellness, PLLC

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## MEDICARE CHIROPRACTIC COVERAGE FOR 2010

### COVERED SERVICES

- Adjustments ONLY
- Supplemental/Secondary Medicare insurance may cover the balance. Some have begun using co-payments. Your coverage depends on your individual policy; we do not determine your benefits.

### NON-COVERED SERVICES\*

- Initial Examination up to \$100.00
- Progress Examinations \$ 25.00
- Surface EMG \$ 25.00
- Traction \$ 7.00
- Exercises \$ 5.00
- All other supplies and procedures

\*Some secondary medical insurance cover these services. You will be liable for your responsibility as determined by your insurance company. Your coverage depends on your individual policy; we do not determine your benefits.

\*These are to be paid at the Time of Service to receive discounted rate.

### YEARLY MEDICARE DEDUCTIBLE (2010) - \$155.00

- Applies to covered Medicare services only

### **Advance Beneficiary Notice (ABN)**

\*\*Medicare will only pay for services which it determines to be 'reasonable and necessary' under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is 'not reasonable and necessary' under Medicare program standards, Medicare will deny payment for that service. I have been notified by my physician that Medicare may deny payment for the services performed, for the reasons stated above. If Medicare denies payment, I agree to be personally and fully responsible for payment of the denied services.

### **Beneficiary Agreement**

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Laura E. Harrington for any services furnished me by that physician. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that Medicare covers only chiropractic manipulation by this physician and I may be charged for additional services. I also authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am financially responsible for all charges not covered by Medicare or by insurance.

X \_\_\_\_\_  
Signature of Beneficiary

\_\_\_\_\_  
Date