

I, \_\_\_\_\_, being a member treated by Dr. \_\_\_\_\_, do hereby  
(Name of Patient/Member/Subscriber) (Chiropractor Name)  
 acknowledge that a certain portion of my care will not be covered by my HMO, insurance company, or health plan under  
 the terms of my Benefit Plan with \_\_\_\_\_. I understand and agree to be responsible  
 to self-pay for the following services: (Name of Health Plan)

**LIST OF SERVICES TO BE PAID FOR BY MEMBER:**

| Date: | Procedure: | Charge:  |
|-------|------------|----------|
| _____ | _____      | \$ _____ |
| _____ | _____      | \$ _____ |
| _____ | _____      | \$ _____ |
| _____ | _____      | \$ _____ |
| _____ | _____      | \$ _____ |
| _____ | _____      | \$ _____ |

Please complete an additional Member Billing Acknowledgment form for additional services.

This form is only to be used if an ASH Plans Health Plan member desires to self-pay for non-covered services. Non-covered services include services such as supplements that are not covered by the member's health plan. Non-covered services may also include services determined by ASH Plans to be maintenance-type services.

The ASH Plans Contracted Chiropractor may not bill the member during the course of an ASH Plans approved treatment program unless there is a copayment, deductible, coinsurance, or the member is receiving non-covered supplements (vitamins, etc.) or non-covered items (supports, appliances, pillows, etc.).

The ASH Plans Contracted Chiropractor may not bill the member for the difference between what the ASH Plans Contracted Chiropractor bills the Health Plan and what the ASH Plans Contracted Chiropractor agreed contractually to accept as payment for services. This difference represents an amount the ASH Plans Contracted Chiropractor agreed contractually to waive.

This agreement may not be used as a "blanket" or "retroactive" agreement to bill members for any services not reimbursed by ASH Plans. Such use will render this agreement "void" and non-binding on the member. This agreement may only be used to allow the member to agree to "self pay" for specific services **in advance**.

I acknowledge that I have been told in advance of treatment what portion of my care I will have to pay for, and agree to make financial arrangements with my chiropractor, Dr. \_\_\_\_\_, to pay for these services myself.  
(Chiropractor Name)

Dated at \_\_\_\_\_, California this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.  
(city) (date) (month) (year)

Member Signature: \_\_\_\_\_  
(Guardian must sign for all members 17 years or younger)

Member Health Plan ID#: \_\_\_\_\_