Dr. John A. Podlaski
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BENEFICIARY AGREEMENT NOT TO USE INSURANCE OR MEDICARE

Dear Prospective Patient,

We do not accept any insurance or Medicare and we do not file insurance paperwork on your behalf for any of the healthcare services we provide.

Medicare only covers active treatment for spinal problems that are medically necessary, acute conditions related to the spine that affect functional capacity. Dr. Podlaski does not provide chiropractic spinal adjustments to Medicare eligible patients. The services we provide are acupuncture, diet, lifestyle, nutritional, and wellness coaching and are NOT currently covered by Medicare for re-imbursement to patients that are seen by a Chiropractic Physician.

EXCLUDED SERVICES
We only recommend the care that is clinically appropriate based upon history, physical examination, diagnostic and laboratory testing. This may include procedures and treatments such as acupuncture, Applied Kinesiology, blood chemistry, Cranial Sacral Therapy, Functional Medicine testing, LENS Neurofeedback Therapy, Neuro Emotional Technique, Nutrition Response Testing, and Nutri-Spec Metabolic Testing or similar treatments. Medicare does not pay for any of these services, treatments or testing procedures performed by a chiropractor, nor do they pay for adjustments to your ankles, cranial bones, elbows, knees, ribs, wrists or other extremity.
By becoming a patient at our office, you are agreeing that none of the consultations, examinations, excluded treatments or services we provide will be billed to Medicare or your insurance company by our office and additionally, that you will not submit to Medicare or your insurance company for re-imbursement for any of the above mentioned excluded services, consultations, evaluations, examinations or treatments.

I,_____ of my own free will, request a consultation, examination or appropriate Medicare excluded treatment or service and that Medicare or insurance will not be billed by Dr. Podlaski or myself for services related to the wellness care services, examinations or treatments I am electing to receive.

_____ _____
Print Name Date signed

_____ _____
Signature of patient or representative Doctor's staff member / date