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MEDICAID COVERAGE FOR CHIROPRACTIC CARE:

My signature below acknowledges that I understand that my Medicaid Insurance will not cover vitamin / mineral supplements, supports, orthotics, therapy, Biofreeze, supplies, and extremity adjustments. I also understand that payment of these services is my responsibility for payment if they are needed. I understand that I may be required to pay a co-payment and that the co-pay is due at the time of each service.

Printed Name

Signature

Date Signed

Witness Signature