PTS
PHYSICAL THERAPY
SERVICES
ORTHOPEDIC AND CANCER PHYSICAL THERAPY

Non-Covered Services Waiver Form

Patient Name: _____ **DOB:** _____

Health Insurer: _____ **Member ID#:** _____

I, the above referenced patient, understand that the services and/or supplies listed below may not be considered eligible for benefits (e.g., services and/or supplies may be determined to be not medically necessary, non-covered or investigational) by the above referenced health insurer.

I also understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements, and non-covered and/or supplies. If I choose to obtain the services and/or supplies listed below, I agree to be financially responsible for any, and all related charges, if they are not covered by my insurance.

☐ **YES,** I choose to receive the following services/supplies, which I understand may be a non-covered service.

☐ **No**, I do not wish to receive the following services/supplies.

Services/Supplies: **TeleRehab**

Conditions/Diagnosis: _____

Approximate Cost of Services: _____

Service Date(s): _____

_____

Patient/Patient Representative Signature **Date**

Relationship to Patient _____

Verbally informed by: _____ **Date:**_____