

physical therapy 180°

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NON-COVERED SERVICES WAIVER FORM

September 9, 2008

I, _____, understand that the services and/or supplies listed below may not be considered eligible for benefits (e.g., service may be determined to be not medically necessary, non-covered or investigational) by my health insurer(s). I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements, and non-covered services and supplies. Since I have chosen to obtain the services and/or supplies listed below, I agree to be financially responsible for any and all related charge(s), if not covered by my insurance.

Physical Therapy

Services/Supplies Requested

Condition/Diagnosis

\$90.00 per visit

Approximate Cost of Service

Date(s) of Service

Patient Signature

Date