Patient Billing Acknowledgement Form
Non-Covered Services
Physical And Occupational Therapy

Under your health plan, you are financially responsible for copayments, co-insurance and deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. For example, this may include items such supplies or durable medical equipment.

The services or products listed below are not covered according to your health plan. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay for the listed services or products.

PROVIDER

Services to be provided:

☐ Supply __________________ ☐ DME ____________ ☐ Other ___________

Time frame from ____________________________ through ____________________________

Schedule/details ____

Provider Signature: ____

PATIENT

I _____________________________________, acknowledge that I have been told in advance by
Patient Name – Printed or Typed

my provider that the services/products listed above are not covered by my Health Plan. I agree to pay for these non-covered services.

Patient/Guardian Signature ____________________________________

Date ______________________________

Patient Billing Acknowledgement Form
Maintenance/Elective Care
Physical and Occupational Therapy

Under your health plan, you are financially responsible for copayments, co-insurance or deductibles for covered services. You are also financially responsible for all non-covered services, including care determined to be elective or maintenance.

Maintenance/Elective care is treatment that does not significantly improve a clinical condition. While being treated for a chronic condition, you may elect to receive care beyond that which is determined to be medically necessary. You may also choose to receive maintenance care once maximum benefit from treatment has been reached.

If, during the course of Maintenance/Elective Care, you develop a new condition or a previous condition becomes significantly worse, care may no longer be considered Maintenance/Elective and may then be covered by your health plan. Your provider must submit a request for insurance coverage.

PROVIDER

Services to be provided are listed below:

☐ Therapeutic Interventions ☐ In-Home Care ☐ Other ______________________

Time frame from __________________________ through ______________________

Schedule/details ____

Provider Signature: ____

PATIENT

I ______________________________________, acknowledge that I have been told in
Patient Name – Printed or Typed
advance by my provider that the services listed above are not covered by my Health Plan and that they meet the above definition of non-covered maintenance/elective care. I agree to pay for these maintenance/elective services.

Patient/Guardian Signature _______________ Date _____________