HM HEALING MOTION PHYSICAL THERAPY

A. Notifier:

B. Patient Name: C. Identification Number:

Non-Covered Services Waiver

NOTE: If your insurance does not pay for D. __________below, you may have to pay. Your insurance does not pay for everything, even some care that you or your health care provider have good reason to think that you need.

D.	E. Reason Insurance May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive D.___________listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but your primary insurance cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.
☐ OPTION 1. I want D.___________listed above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment. I understand that if my insurance doesn't pay, I am responsible for payment, but **I can appeal to my insurance.** If my insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ OPTION 2. I want D.___________listed above, but do not bill my insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if my insurance is not billed**.
☐ OPTION 3. I don't want D.___________listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my insurance would pay.**

H. Additional Information: This notice gives our opinion, not an official insurance decision. If you have other questions on this notice or billing, call the number on your insurance card. Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: