



Dr. Iwona L. Ciba

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WAIVER OF LIABILITY

Patient Name _____ Date _____

SS# _____ - ____ - _____

DOB _____

Dear Patient:

Medicare/Insurance will only pay for the services that it determines to be “reasonable and necessary” under section 1862(a)(1) of the Medicare Law. If Medicare/Insurance determines that a particular service, although it would otherwise be covered, is “not reasonable and necessary” under Medicare/Insurance program standards, Medicare/Insurance will deny payment for that service. I believe that in your case, **Medicare/Insurance is likely to deny payment:**

() L3020 Custom Orthoses, molded to patient foot – fee \$350 .00

() A9160 Non-Covered Routine Foot Care – fee \$45.00

Medicare/Insurance usually does NOT pay for this service/equipment.

() **PATIENT’S AGREEMENT:** I have been notified by my Physician that, in my case, Medicare/Insurance likely to deny payment for this services. If Medicare/Insurance denies payment, I agree to be **personally and fully responsible for payment.**

() I have decided **NOT** to receive these items or services.

Signature of Patient _____ Date _____