



**Dr. Iwona L. Ciba**

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***WAIVER OF LIABILITY***

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

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:**

( ) L3030 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 \_\_\_\_\_