

**Ando & Aston Physical Therapy
WAIVER OF LIABILITY – OUTPATIENT SERVICES**

Dear Patient:

This form is used for all patients who wish to receive healthcare services from Ando & Aston Physical Therapy and have their insurance company billed for those services. The rules that govern payment for services are unique to each insurance payer, and some services received may not be covered by your specific insurance policy. **The fact that your insurance may not pay for a particular item or service does not mean that you should not receive it.** There may be a good reason why your doctor and physical therapist have recommended it. Your insurance company may add or change coverage policies, at will, that could affect their payment for your services received at Ando & Aston Physical Therapy.

Under your health plan, you are financially responsible for any co-payments, co-insurance and deductibles for “covered services”. You are also financially responsible for all **non-covered services**, including any service determined by your insurance company to be: “not covered”, “not medically necessary”, “not authorized”, “patient share”, “patient responsibility”, “maintenance”, “not supported by documentation” or otherwise deemed a non-payable benefit. This determination also includes any service for which your insurance company changes the number of units of service from that which was actually delivered to some other quantity. (Including, but not limited to CPTcodes: 97001 through and including 97750) This includes determination of non-payment based on a post-service claims review basis, also known as retroactive denial.

Your signature on this form acknowledges that you agree to bear full financial responsibility for all non-covered services provided at Ando & Aston Physical Therapy including, (but not limited to) manual therapy, passive modalities (such as ice, heat, electrical stimulation, ultrasound), taping, therapeutic exercise, therapeutic activities and/or neuromuscular reeducation.

We look forward to working with you at Ando & Aston.

**Art Ando, MS, PT, CFMT
Gary Aston, PT, CFMT**

By my signature below I agree to be financially responsible for payment of all services received.

Responsible Party or Responsible Party’s
Legal Representative Name (PLEASE PRINT)

Date: _____

Responsible Party or Responsible Party’s
Legal Representative Signature

Ando & Aston Physical Therapy Representative Name
(PLEASE PRINT)

Date: _____

Ando & Aston Physical Therapy Representative Signature