Non-Covered Services Statement

As your Occupational Therapist, I want to provide you with the best care possible. There are services that I feel are necessary for the treatment of your condition and maintenance of good health that are not covered by your health benefits contract. You are expected to pay for those services in full. Let me reassure you that I will order only the tests and treatments that I feel are necessary for your treatment and care.

If you have any questions about whether or not a particular service is covered by your health benefits contract, someone in our office will be happy to assist you. Thank you for your understanding.

Patient Signature **Date** **Possible Non-Covered Services and Monies Due**

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* I have read your policy and agree to pay for the services outlined above that are not covered by my contract as indicated by my signature for each date above.