Dr. Iwona L. Ciba
25722 Kingsland Blvd, Suite 201B • Katy • TX 77494
Tel. (281) 395-9966

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 or apply to deductable:**

( ) L3020 Custom Orthoses, molded to patient foot – fee $450 .00

( ) A9160 Non-Covered Routine Foot Care – fee $55.00

( ) Ingrown Toenail Surgery -Deposit $150.00 – refundable upon insurance payment

Medicare/Insurance usually does NOT pay for this service/equipment or applies to deductable.

( ) 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 full payment**.

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

Signature of Patient ______________________________________ Date ___________