Medicare Waiver

MEDICARE WAIVER

Provider Name: _____ **Consent:** _____

- [ ] I agree to receive physical therapy treatments from the provider mentioned above. The provider has no relationship or signed contracts with Medicare.
- [ ] I am waiving all rights to Medicare coverage and have chosen to pay cash on my own choosing due to the specificity of the Schroth Method as well as other scoliosis specific treatment and its unavailability in other practices that accept Medicare.
- [ ] I will not submit any claims to Medicare and will assume full responsibly for the cost of the treatments at Almonte Physical Therapy.

Name: _____

Signature:
Date: _____ dd / mm / yyyy