## Practice Name

## Non-Covered Waiver

## Custom Foot Orthotics

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

The purpose of this notice is to help you make an informed choice about whether you wish to proceed with custom foot orthotics.

As you know, your insurance does not pay for all of your healthcare costs. Some items and services are not considered “covered benefits” under your health insurance plan and as such, your insurance will not pay for these services.

Your chiropractor believes that your current health condition may improve with custom foot orthotics. However, health care plans have very specific requirements regarding when custom foot orthotics are medically necessary and when they will be covered by your plan. In the opinion of your chiropractor, your need for custom foot orthotics *may not be consistent with your plans requirements regarding the medical necessity requirements of custom foot orthotics.*

Since we do not know whether the custom foot orthotics will be considered a covered benefit under your health plan, should you choose to have our office order orthotics for you, you must first agree to be personally responsible for the payment of the orthotics. (**Please note**: Our office will file claims to health care plan for the orthotics and should the plan determine the orthotics are medically necessary and provide payment for them, this office will promptly refund the monies you have paid for the orthotics.)

The cost of the orthotics is $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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I acknowledge that I have been informed in advance of ordering the orthotics that these services may not be covered by my health insurance plan. I have chosen to receive the orthotics and understand that I will be financially responsible for the charges indicated above.

Name of patient/parent/legal guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient/parent/legal guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form must be signed by the patient or legal guardian PRIOR to ordering the orthotics; a copy must be provided to the patient, and the original form *must be maintained in the patient’s medical record.*