2018 NON-Covered Therapy Explanation & Billing Consent

Certain services provided to you are not considered medically necessary by your health plan. While these services are extremely important to your recovery, the terms of your health care plan do not pay for them. The non-covered services and/or supplies are the responsibility of you, the patient.

You, as the patient do have the choice to pay our cash price versus billing your insurance. Otherwise known as TOS or Time of Service Discount. This discount is applied to the total of services not being billed to your insurance, when paid the same day out of pocket. One $25 discount will be applied to your services per visit. Prices are as shown below.

Service:	Charge:	TOS Discount:	TOS Price:
ART/AMIT	$45.00	$25.00	$20.00
Initial Exam	$108.00 - $176.00	$25.00	$83.00-$151.00
Re-Exam	$59.00-$108.00	$25.00	$34.00-$83.00
ART & Extremity	$75.00	$25.00	$50.00
Laser Treatment	$50.00	$25.00	$25.00

*This discount is applied to the total of your services when paying at the Time of Service and not billing insurance. **One Discount applied per visit total***

Common insurance companies that will not cover these services are listed below:

- Group Health Cooperative/ Medicare/Medicare Replacement Plans/Supplemental Plans

I, _____, while under the care of Pearson and Weary Pain Relief Clinic, acknowledge and agree that if part of my care may not be a covered benefit of my healthcare plan; I acknowledge and understand that if this is true with my plan, I will be financially responsible for this part of my treatment. I also acknowledge and understand the information listed below.

By signing this document, I am agreeing to pay for these services and charges at the time the services are rendered. By paying for these services at the time of care, and only at the time of care, I will be offered a discount of $25.00 to my total balance due. I also acknowledge if I do not pay for these services at the time of my care, I do not receive a discount, and will be billed the usual and customary price. I also acknowledge that I do not receive a discount on any supplies and/or supplements purchased. There is a 60 day return policy on supplies, and a 7 day return policy for all UNOPENED supplements.

Patient Name: _____

Patient Signature: _____Date:_____