INSURANCE COVERAGE WAIVER

Patient Name: _____ **DOB:** ____/____/_____

Carlson Therapy Network, PC (DBA Carlson Procare) is a participating provider with your medical insurance:

_____

(**insurance company name**)

Your insurance company does not pay for every charge, even some that you and/or your healthcare provider have good reason to think you need. We expect that your health plan may not cover the following:

A. Services	B. Reason Insurance May Not Pay	C. Estimated Charges

Notification:

- Please read this notice to make an informed decision about your care.
- Ask Carlson Procare's staff any questions you may have regarding this notice.
- Choose an option below regarding the services described in (A) above

Options: Please check only one box. We cannot choose for you.

❑ **OPTION 1:** I want (A) _____ listed above. Carlson Procare may require payment at the time of service, but I also elect to have my insurance plan billed for an official decision on payment, which is sent to me on an Explanation of Benefits (EOB). I understand that if my insurance does not pay, I am responsible for payment.

❑ **OPTION 2:** I want (A) _____ listed above, but I do NOT want these charges billed to my insurance plan. Until further notice, I elect to self-pay at a rate of $_____ for the initial evaluation and $_____ for all follow-up visits in this current episode of care.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Parent/Guardian/Responsible Party **Date**

_____

Relationship to Patient