Medicare  
INFORMED CONSENT  
Agreement to Pay

This form must be complete in full before providing a non-covered service or item to a Medicare patient.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic: \_\_\_\_*Woodinville Physical Therapy*\_\_\_\_\_\_\_\_\_\_ Patient Account #:\_\_\_\_\_\_\_\_\_\_\_\_

* I understand that the specific services listed below **ARE NOT** covered by Medicare.
* I choose to receive these specific services.
* **I agree to pay for these specific services**

Specific Services Patient Agrees to Receive and Pay For:

**Any Physical Therapy Charges That Exceed The Medicare $1960 Therapy Cap.**

The above services are not covered by Medicare because:

* As of January 1, 2015 Medicare has placed a $1940 cap per calendar year on all outpatient physical therapy.

This agreement is void and unenforceable and I am under no obligation to pay the provider, **IF** my medical program covers the services listed above or if the provider fails to satisfy Medicare’s conditions of payment as described under WAC 388-502-0160.

**I understand this form and all my questions were answered to my satisfaction.**

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Signature of Patient/Parent/Guardian Representative Date

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Signature of Interpreter (If Required) Date

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Authorized Staff Signature Date