Alison Palmer
Physical Therapy &
Wellness Center

Medicare/Medicaid Waiver

I (Print Name)_____ Understand that as a Medicare/Medicaid beneficiary,

1. I refuse to authorize Alison Palmer Physical Therapy & Wellness Center to submit any invoices to medicare.
2. I cannot apply to Medicare/Medicaid on my own for reimbursement of services provided by Alison Palmer Physical Therapy and Wellness Center LLC.
3. I cannot bill my secondary insurance, because the primary (Medicare) cannot be billed.
4. I will not receive an invoice/bill from Alison Palmer Physical Therapy & Wellness Center.
5. Payment at the time of service is the policy of Alison Palmer Physical Therapy & Wellness Center.
6. Services provided will be performed as wellness and/or preventative treatment.

Signature:_____Date:_____

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