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Greenville, NC 27834
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Cash-Pay Rehabilitation & Gait Training Consent Form

****Provider:**** _____

****Patient Name:**** _____

****Date of Birth:**** _____

Purpose of this Agreement

You are choosing to receive rehabilitation, exercise, or gait training services from Orthotics & Prosthetics East, Inc. These services are considered non-covered services under Medicare and other insurance programs when provided through a DME supplier. Because Orthotics & Prosthetics East, Inc is enrolled with Medicare only as a Durable Medical Equipment (DME) supplier, we cannot and will not bill Medicare or other insurances for these services.

Important Information

- These services are considered statutorily excluded and are not eligible for insurance reimbursement.
- Services are available only on a cash-pay basis.
- You are responsible for payment in full at the time of service.
- You may choose to receive these optional wellness/training services here, or you may seek covered physical therapy services from a Medicare-enrolled therapy provider if you prefer.

Fees

Per Session Fee: \$ _____

Package Option: \$ _____ for _____ visits

Consent & Acknowledgement

I have read and understand this agreement. I acknowledge that:

- The services I receive today are not covered by Medicare or other insurance programs when provided through a DME supplier.
- I am responsible for full payment.
- I will not request that Orthotics & Prosthetics East, Inc submit claims for these services.
- I consent to participate in cash-pay rehabilitation, exercise, or gait training sessions.

Patient/Responsible Party Signature: _____ Date: _____

Provider/Witness Signature: _____ Date: _____