



## TUFTS NON-COVERED SERVICE WAIVER FORM

**Provider Statement:** The purpose of this waiver form is to inform Tufts Health Plan members, before they receive a medical service, that the service(s) listed below is a non-referred or not medically necessary or experimental/investigative service. By signing this form, I the provider acknowledge and agree that I have explained to the member that the service(s) listed are not covered by the health plan.

Dr. Brett Coapland and/or Dr. Kanoa Pornelos-King

Provider Signature

Date

### NON-COVERED PROCEDURES/TREATMENTS AND ESTIMATED FEES

Patients will be responsible for the following, non-covered fees:

- Manual Therapy treatment(s) — \$20 per visit
- Treatments that are dependent on a patient's condition, diagnosis, and physician recommendation include:  
Extremity Conditions treatment — \$50 per visit, as needed for treatment of extremities
- Dry needling — while not covered, there is no charge to you for this service
- Kinesio-taping — while not covered, there is no charge to you for this service

### PATIENT STATEMENT AND AGREEMENT

I have been informed by the provider indicated above in advance that the service(s) listed above that are not medically necessary or are experimental/investigative are not covered. I understand and agree that I am responsible for payment of the provider's charges for these services to the provider of service.

Printed Patient Name

Patient/Guardian Signature

Date