NSM Waiver of Benefits
(Non-Medicare)

Client Name: _____

Address: _____

City/St/Zip: _____

Work Order #: _____

I, _____, am requesting to purchase the item(s) and/or service(s) listed below and I voluntarily waive my rights to have National Seating & Mobility (NSM) submit a claim on my behalf to my health insurance company. I understand that I am fully responsible for the total billed charge.

I understand and acknowledge that by choosing to waive my benefits, NSM cannot file a future claim for the item(s) and/or service(s) and reimburse what I paid. I also understand that I cannot file a claim on my own. I understand that by waiving my benefits, I am forfeiting my right to have my insurance carrier determine if the item(s) or service(s) are medically necessary and forfeiting my health insurance paying for them.

I further understand and acknowledge that any future services or repairs related to the item(s) and/or service(s) will also be non-covered by my health insurance plan, and if such future services or repairs are requested by me, I will be financially responsible for such services or repairs.

I acknowledge and understand that NSM is not the manufacturer of the requested item(s), did not prescribe the requested item(s) and makes no representations with regard to medical suitability of the requested item(s) and/or service(s).

I acknowledge that I am signing this waiver voluntarily at my own request and that it is not being signed under duress or after the item(s) or service(s) have already been provided.

Item(s) and/or Service(s): **Estimated Cost:**

_____ _____

_____ _____

_____ _____

Patient's name: _____

Patient's signature: _____ **Date Signed:** _____

Authorized representative's name: (please print) _____

Authorized representative's signature: _____ **Date Signed:** _____

Relationship to patient: _____

Reason patient cannot sign: _____