

Central Coast Lymphedema Therapy
1061 Murray Ave., San Luis Obispo, CA 93405
(805) 782-9300 – Fax (805) 782-9700
Email – cclymph@hotmail.com

MEDICARE ONLY

Patient Name: _____

ASSIGNMENT OF BENEFITS

____ I hereby assign and authorize payment directly to Central Coast Lymphedema Therapy for any and all medical benefits for services provided by Central Coast Lymphedema Therapy. I understand that I am financially liable to Central Coast Lymphedema Therapy for charges not covered and paid by this authorization or services not deemed medically necessary by Medicare or any secondary and/or supplemental insurance I have.

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS

____ I have been informed and understand that Medicare has an annual payment limit and won't pay for charges beyond \$1,860. If I choose to continue therapy after this limit has been reached, I understand that I will be financially liable for any charges.

Signature of Consenting Patient/Guardian

Date

Witness

Date