

TRICARE WAIVER

By signing the CFCG Tricare Waiver I agree to and acknowledge that the following conditions apply:

I acknowledge that my provider and all providers at CFCG may bill charges that are above the legal limit of 15 percent above the TRICARE allowable charges.  
([www.tricare.osd.mil/News/1998/news98\\_Nov6.htm](http://www.tricare.osd.mil/News/1998/news98_Nov6.htm))

I wish to continue seeing my provider(s).

I agree to be responsible for payment of such items or services including but not limited to: 90801- Diagnostic Evaluation, 90806 – Individual Psychotherapy/45 Mins., 90846/90846-Family Psychotherapy, 90804-Individual Psychotherapy/30Mins., 90853-Group Psychotherapy, 90862-Psychopharmacological Management, 90805/90807-Medication Management with Therapy, 96101/96102 Psychological Testing, 96116-Neurobehavioral Status Exam, 96118/96119-Neuropsychological Testing, and I am willing to pay the extra charges.

I will attach a copy of this waiver to all of my Tricare claims.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these services knowing that you will be paying more than the amount allowed by Tricare. In signing this waiver you are agreeing to the above terms and fee schedule which you have also been provided and agreed to. If you have any questions or concerns, please discuss them with your provider(s).

\_\_\_\_\_  
Patient/Guarantor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

02/09