C.H.O.O.S.E Physical Therapy, LLC

Medicare Information Sheet

(For all Traditional Medicare patients only, Not Managed Care Plans)

1. We are a Medicare Part B provider and will accept Medicare's fee schedule for services rendered. About 5 weeks after your appointment Medicare will pay for 80% of the allowed amount for services.

2. Deductible and remaining co-insurance may be paid by your secondary insurance. C.H.O.O.S.E Physical Therapy bills the secondary insurance as a courtesy to our patients, but the patient is responsible for all deductible and co-pay/co-insurance. Under no circumstances will the deductible or co-pays be waived.

3. Medicare guidelines require a prescription from a Physician and functional deficits, difficulty with activities of daily living to reimburse us for services rendered. (Please discuss this with your therapist after the initial evaluation).

4. Medicare will not pay for physical therapy at our facility if the patient is receiving any type of **home care including home health aide, nursing, occupational, social work, wound care, anyone in the health care field or physical therapy.** If I am receiving any home care and do not disclose this to C.H.O.O.S.E Physical Therapy, I will be responsible for payment for all serviced rendered.

5. I Understand the information as provided to me:

Patient's Name:_____ Patient's Signature:_____

Date: _____

Medicare has a limit on Physical Therapy benefits per year. We need the following information to obtain your current benefits status.

I have not received Physical Therapy, Occupational Therapy, Speech Therapy or Home Health Care this year for my current injury or condition of for any other injury or condition.

Patients Name: _____ Patient's Signature: _____

Date:_____

I have received previous treatment this year for my current injury or condition.

Facility: _____Dates:_____to:_____Number of visits:_____

I have received Physical Therapy, Occupational Therapy, Home Health Care or Speech Therapy this year for an injury or condition.

Facility: _____Dates:_____to:_____Number of visits:_____

Patients Name:_____ Patient's Signature:_____