NOTICE TO MEDICARE PATIENTS

Medicare's Coverage:
Medicare will cover only those services deemed medically necessary and ordered by a physician. Medical necessity is determined by the referring physician and physical/occupational therapist. Medicare's benefits include a $240 deductible and then cover 80% of allowable charges once the deductible is met. The remainder will be your responsibility. If you have a secondary insurance the 20% coinsurance will be billed to them. Your benefits with the secondary insurance will determine if you incur any charges. Medicare is capped at $2,330 for 2024 for Physical and Speech Therapy combined and $2,330 for Occupational Therapy. There are "exceptions" to this cap that are listed by Medicare, which will allow coverage beyond the $2,330 cap.

1. **Have you had Physical Therapy and/or Speech therapy, or Occupational Therapy previously this year?** ☐ **YES** ☐ **NO**

2. **Are you now or have you recently received home health care this year?** ☐ **YES** ☐ **NO**

3. **Medicare will not pay for outpatient Physical Therapy or Occupational Therapy while you are receiving home health care. If you have received home health care recently, have you been formally discharged from their care?** ☐ **YES** ☐ **NO** ☐ **N/A**

4. **Are you currently working?** ☐ **YES** ☐ **NO**

5. **Is your condition due to an auto accident?** ☐ **YES** ☐ **NO**

We will send a Plan of Care to your referring physician after the initial evaluation and at least every 30 days or 10 visits after. The Plan of Care consists of a treatment plan and the frequency and duration. Treatment is based on initial evaluation findings and your diagnosis. Medicare will cover only treatment that is intended to improve functional ability. Your physician may require you to return to their office before they allow additional treatment.

I have read and understand all of the above information pertaining to my Medicare benefits for Physical and/or Occupational Therapy.

Patient Signature: _____ **Date:** _____

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PATIENT INTAKE & CONSENT FORM

Patient Name: _____

Birth Date: _____ Social Security #: _____

Gender: ◯ Male ◯ Female Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Insured Address (if not self): _____

City: _____ State: _____ Zip Code: _____

Insured Birth Date: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

By providing us with your landline or cell phone number(s), you give consent for us, our agents, and our collection agents, to contact you at these numbers, or at any number that is later acquired for you, and to leave live or pre-recorded messages regarding any accounts or services. You are also giving consent for us to deliver these calls by an automatic dialer. Providing us a telephone number or cell phone number is not a condition of receiving our services however.

Email address: _____

**Email for internal use only*

Employer Name (of patient or parent): _____

Prior Physical Therapy (chiropractic, home care, etc.) this year? ◯ Yes ◯ No # of Visits: _____

Referring Physician: _____

Primary Care Physician: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This release of information will remain in effect until terminated by me in writing. This information is released to:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

☐ Do NOT release information.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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CANCELLATIONS AND NO SHOWS

Cancellations and no shows affect a person's ability to succeed in treatment. The physician and therapist prescribe a set frequency of treatment. The patient's role is to appear for appointments and follow the therapist's instructions so we will be able to help you achieve your goals in treatment. To encourage regular attendance:

1. We require a 24-hour notice in the event of a cancellation.
2. A $25.00 charge will be assessed for a cancellation without proper notice and a $50.00 charge for a no-show. These charges are not covered by your insurance, and are due at the next scheduled visit.
3. Renue Physical Therapy reserves the right to terminate treatment if a patient cancels and/or misses three scheduled appointments.

CO-PAYS/DEDUCTIBLES

As a courtesy, Renue Physical Therapy will call your insurance company to check your benefits. Co-pays are expected at time of service and deductibles will be billed to the patient after we hear from your insurance company. Patients are encouraged to contact their insurance company and verify their coverage/benefits.

NOTICE OF PRIVACY PRACTICES

I have read and understand the HIPAA Notice of Privacy Practices that was provided to me on this day. (upon request)

WORKER'S COMP/AUTO CLAIMS

Documentation of any missed appointments will be forwarded to your Case Manager/Adjustor and Primary Care Physician. This could jeopardize your claim.

FINANCIAL AGREEMENT/TREATMENT CONSENT/ASSIGNMENT

In consideration for services rendered, I hereby authorize payment to Renue Physical Therapy. In addition, I authorize the release of any medical information necessary to process this claim. The undersigned agrees, as patient or agent of patients, that the patient is accepting financial responsibility for services rendered and is obligated to pay their balance due at time of service and all balances that may be denied by your insurance company after we file a claim. No treatment for any condition or disease is without side effects and physical therapy is no exception. Fortunately, with the hands-on techniques and therapeutic exercises utilized by the therapist, any unwanted side effects are usually minor and limited. By signing below you indicate you are aware of, and accept the risks of physical therapy treatment, and give your full consent for the therapists at Renue Physical Therapy to provide such treatment.

*Medicare patients receiving home health services of any kind are NOT eligible for outpatient physical therapy.

Patient Signature: _____ **Date:** _____

Parent/Guardian: _____ **Relationship:** _____
(If patient under 18 years old)

Witness Signature: _____ **Date:** _____

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MEDICAL HISTORY

Patient Name: _____ Date: _____

Height: _____ Weight: _____ Next Doctor's Appt: _____ Date Problem Began: _____

Please mark Yes/No for the following conditions with descriptions as appropriate

Yes __ No __ Heart Attack _____

Yes __ No __ Stroke/TIA _____

Yes __ No __ High Blood Pressure _____

Yes __ No __ Pacemaker/Defibrillator _____

Yes __ No __ Other Cardiac Issues _____

Yes __ No __ Diabetes _____

Yes __ No __ Multiple Sclerosis _____

Yes __ No __ Parkinson's _____

Yes __ No __ Seizures _____

Yes __ No __ Concussion ___ _____

Yes __ No __ Traumatic Brain Injury _____

Yes __ No __ Cognitive/Memory Changes _____

Yes __ No __ Cancer _____

Yes __ No __ Anxiety/Depression _____

Yes __ No __ Autoimmune Conditions _____

Yes __ No __ Osteoporosis _____

Yes __ No __Fibromyalgia _____

Yes __ No __ Change in Bowel/Bladder _____

Yes __ No __ Numbness Tingling _____

Yes __ No __ Currently Pregnant _____

Yes __ No __ Falls in the past year? If yes, how many in the past year? _____

Please explain if answered "Yes" to any of the above: _____

_____

_____

_____

Please list any infectious diseases you have (ex: Hepatitis, HIV/AIDS, MRSA, C-Diff, Chicken Pox, Staph, Influenza, etc.): _____

Please list any skin conditions you have (ex: Ring Worm, Scabies, Dermatitis, Psoriasis, etc.): _____

_____

Please list any surgeries and approximate dates, including any metal/plastic implants: _____

_____

_____

Diagnostic Testing (X-ray, MRI, CT scan, EMG, etc.): _____

Current Medications (or provide list): _____

_____

Allergies: _____

Other Concerns: _____