



WELCOME 2012 Medicare Beneficiary!

Dear Patient:

Welcome to Twin Boro Physical Therapy, where we have been committed to serving all our patients' with the highest quality of care, helping each patient achieve their goal of feeling a difference!

As of January 1, 2012, Congress has voted for the Medicare financial limit or cap for physical and occupational therapy to be extended until the end of 2012.

The limit has been set to \$1880.00 per year.

What does this mean to you?

As a patient in an outpatient facility, you are entitled to \$1880 of coverage for your outpatient physical therapy and speech therapy combined and \$1880 of coverage for outpatient occupational therapy. This limit is for the year and not per diagnosis.

If you have received physical or occupational therapy within the calendar year, either with us or with another provider, please notify our front office staff.

We, as a provider, are responsible for accessing your progress throughout your treatment. As you approach the limit imposed by Medicare, your therapist will discuss with you whether or not continued treatment is considered medically necessary and will result in an improved outcome or maintain your current status. We will assist you in making an informed choice about continuing therapy after meeting the limit set by Medicare.

Medicare does give the beneficiary the option of continuing to treat with your current Outpatient Physical Therapy facility if treatment is considered medically necessary, or at your request, you may continue to obtain treatment at a Hospital Outpatient Therapy Facility, where Medicare will continue to cover your treatment after the Medicare limit has been met.

Should you choose to continue your services with Twin Boro Physical Therapy after the therapist determines that any additional progress will be limited and is not considered medically necessary, you will treat as a self pay patient, responsible for \$65.00 per visit.

We appreciate that you have chosen Twin Boro Physical Therapy to provide you with your therapeutic care.

We will do our utmost to assist you with any questions you may have concerning this new cap put into effect for the 2012 calendar year.

Thank you.

Patient's Initials _____



Consent to Treat/Release of Information

CONSENT TO EVALUATE AND TREAT

I do hereby consent to the evaluation and treatment by TwinBoro Physical Therapy Associates. I understand that it is my right to accept or refuse any treatment offered me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

RELEASE OF INFORMATION

I authorize TwinBoro Physical Therapy to release information from my medical record, whether it be written, video, photographic, audio or verbal, to my physician and/or any third party payor (such as insurance company or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication with custodians of records. I consent to the release of medical information to _____ for communication and care coordination on my behalf.

PRIVACY PRACTICES

I acknowledge receipt of the TwinBoro Notice of Privacy Practice, which I have received at the time of this initial visit or previously.

ASSIGNMENT OF BENEFITS

I request that payment of Medicare and/or other insurance benefits be made on my behalf to TwinBoro Physical Therapy Associates for any services furnished to by TwinBoro Physical Therapy.

FINANCIAL AGREEMENT

The undersigned agrees, whether signing as agent or patient, that s/he individually obligates her/himself to pay for services rendered in accordance with the regular rates and terms of TwinBoro Physical Therapy Associates. TwinBoro will verify insurance benefits on behalf of the patient. Verification is no guarantee of payment. The agent/patient is responsible for any co-payment, deductible, coinsurance and all amounts identified by the insurer as the patient's responsibility.

INSURANCE COVERAGE

I understand that if I fail to disclose any effective insurance coverage at the time of this signing or after the first service date when said insurance became effective, I can be held responsible for any balances not covered by said insurance. This includes balances due to lack of authorization.

- I do not have secondary coverage
- I choose not to use my secondary coverage

HOME HEALTHCARE

As a Medicare beneficiary, I am aware that I can not receive physical therapy through an independent clinic if I am currently enrolled with a Home Healthcare Agency. If services were provided and I was not formally discharged by the agency, I realize that I will be held responsible for services denied by Medicare.

Patient Initials I have received some form of home healthcare _____ I have not received some form of home healthcare
Patient Initials

MEDICARE PRIMARY HORIZON BLUE CROSS BLUE SHIELD SECONDARY

Although Medicare will cover an evaluation and/or re-evaluation procedure, Horizon BCBS does not pay for these procedures. Should Horizon deny, the patient will be held responsible for the Medicare coinsurance on these and any other services Horizon deems patient responsibility.

The undersigned certifies that s/he has read, understood and accepts the terms of this form, received a copy, and is the patient or is duly authorized by the patient as the patient's general agent to execute this form.

Signature of Patient or Responsible Party

Date

Witness

Date

Account Number