Health Rehab
PHYSICAL • SPORTS • AQUATIC THERAPY

1844 North University Drive, Coral Springs, FL 33071 Phone: 954-255-1515 Fax: 954-255-1445

Medicare Patients

Effective January 1st, 2015, Medicare now has a combined benefit cap of $1,940 for Physical Therapy and Speech Therapy, and a separate benefit cap of $1,940 for Occupational Therapy. A cap of $1,940 is equivalent to approximately 15 - 17 visits of therapy per year. This cap applies to all health care settings except Outpatient Hospital Departments.

As a courtesy, Health Rehab will track your therapy cap during your treatment here. Our staff will notify you as you begin to approach the limit of your therapy benefit. If you, your therapist, and your doctor feel that you need and would benefit from continued therapy, then the following options will be discussed with you:

- Continue therapy at Health Rehab at a discounted, cash pay rate

OR

- Discontinue therapy at Health Rehab and be referred to an outpatient hospital clinic

Please answer the following questions:

Have you received any therapy services (physical therapy, occupational therapy, speech therapy) during the current calendar year? ☐ **yes** ☐ **no**
If yes, what type of therapy? _____ When?_____

Have you received any Home Health Care services (therapy, wound care, diabetic care, nursing / aide, etc…) in the past 60 days? ☐ **yes** ☐ **no**

I acknowledge that I have read the above, and I understand my therapy benefits and options.

_____ _____
Patient Signature Date

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Patients Name: _____

I certify that the information given by me in applying for payment under Title XVII of the social security act is correct. I authorize any holder of medical of other information about me release to the Social Security Administration or its intermediaries of carries any information for this or any Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of the medical insurance benefits either to myself, or the party who accepts assignment. I understand that signing this authorization may cause Medicare payment information to cross over automatically to my supplemental insurer. I understand that I am financially responsible for charges not covered by this authorization.

_____ _____

Patient Signature Date

Medicare Secondary Patient Questionnaire

1. Are you currently employed? Yes No
   Name of Employer: _____
   Address of Employer: _____
2. If married, is your spouse currently employed? Yes No
3. Do you have employer group health plan coverage? Yes No
   Name of Group Health Plan: _____ Group#_____
   Address: _____
   Name of Policy Holder: _____ Relationship to patient: _____
4. Does the employer that sponsors your group health plan employ 20 or more employees? Yes No
5. Are you receiving Black Lung Benefits? Yes No If so, what date did the benefits begin?_____
6. Was this injury/illness due to a work related accident/condition? Yes No
   Name of Workers Compensation Plan: _____
   Address: _____
   Name of Employer: _____
   Address: _____
   Date of Injury: _____ Claim number: _____
7. Was this Injury/illness due to an auto accident? Yes No
   Name of No-Fault or Auto Liability: _____
   Address: _____
   Date of Accident: _____ Claim number: _____
8. Are the services to be provided going to be paid by government program (other than Medicare), such as a research grant? Yes No
9. Are the services to be provided going to be paid by the Veterans Affairs? Yes No

_____ _____

Patient Signature Date