Performance PHYSICAL THERAPY

Did You Know Before You Go? Medicare Part B

Patient Name: _____ **DOB:** _____

Medicare Policy#: _____ **Dx:** _____

Part B effective date: _____ **DOS:** _____ **Acct#:** _____

Patient portion—Please mark appropriately:

Are you currently receiving:

Home Health	☐ **Yes**	☐ **No**
Hospice	☐ **Yes**	☐ **No**

Or residing in:

Skilled Nursing Facility	☐ **Yes**	☐ **No**
Intermediate Care Facility	☐**Yes**	☐ **No**

Have you been seen for therapy at another facility at any time this year? ☐ **Yes** ☐ **No**

Your benefits:

- **The annual deductible is $185.00; the remaining deductible amount is $** _____
- **Medicare Primary: YES NO**
  - **Medicare will pay 80%; you will be billed 20% of the allowable.**
- **Your therapy benefits allowed:** ☐ **$2040.00 therapy threshold PT/SPT combined for 2019**
  ☐ **$2040.00 therapy threshold OT for 2019**
  - **Medicare Therapy benefits used this year: PT:** _____ **OT:** _____
- **Special instructions** _____

If your deductible has not been met, you will be responsible for the outstanding charges in addition to any other co-insurance and/or co-pays. Medicare only pays for covered benefits; ALL BENEFITS ARE SUBJECT TO MEDICAL NECESSITY. This verification is performed by an Orthopedic & Sports Physical Therapy staff member as a courtesy and DOES NOT represent a guarantee of payment by your insurance company.

I fully understand that I am financially responsible for any services not covered by my insurance.

Patient/guardian signature: _____ **Date**_____

Relationship to patient: _____

Verified By: **Date:**