

# Myofascial Physical Therapy

## Medicare New Patient Information

LAST NAME	FIRST NAME	DATE OF BIRTH	AGE
STREET ADDRESS		SOCIAL SECURITY NUMBER	
CITY	STATE	ZIP	HOME PHONE
CELL PHONE	FAX		
EMAIL ADDRESS (we send occasional information about classes and events, we will not share your address with others)			

### EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP	HOME PHONE	OTHER PHONE
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PLEASE PRESENT INSURANCE CARDS FOR COPYING

### MEDICARE INFORMATION

ID NUMBER	Do you have Medicare Part B?	YES	NO			
Have you met your deductible?	YES	NO	Have you received PT or OT elsewhere this year?	YES	NO	If yes, how many sessions?

### SECONDARY INSURANCE INFORMATION

SUBSCRIBER NAME	SUBSCRIBER DOB	SUBSCRIBER SOCIAL SECURITY NUMBER
SECONDARY INSURANCE COMPANY		

### REFERRING PHYSICIAN INFORMATION

NAME	PHONE
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### Appointment Etiquette

**In order to ensure that we are able to continue providing specialized service to you and all of our clients, we require that you give the courtesy of 24 hours notice if you need to cancel or change an appointment. You will be charged a cancellation fee of \$115 without exception for missed appointments without such notice.**

I hereby give permission to Myofascial Therapy to release any information requested by my insurance company acquired in the course of my examination and treatment. I hereby authorize and direct my insurance benefits to be paid directly to Myofascial Therapy. I am financially responsible for non-covered services. I hereby give permission to the therapist to administer treatment and perform such general procedures as deemed necessary in the diagnosis and/or treatment of my condition. I hereby authorize and request any/all physicians involved in my care to release to Myofascial Therapy, 201 E. Hamilton Ave., Campbell, CA 95008, 408-376-0900, the complete history records in their possession concerning any treatment or examination rendered to me during treatment of this diagnosis.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**PLEASE READ AND SIGN THE BACK SECTION OF THIS FORM**

# Notice of Exclusion from Medicare Benefits

Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. Some items and services are not Medicare benefits and Medicare will not pay for them. When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

**Medicare has put a limit, or cap, on the amount of outpatient therapy services you can receive in one year, of which they will pay 80%. Visits beyond the cap are not Medicare covered benefits. The caps for 2010 are as follows:**

<b>Physical Therapy and Speech Therapy:</b>	<b>\$1860</b>
<b>Occupational Therapy:</b>	<b>\$1860</b>

**At our facility, this amounts to approximately 12-15 sessions. Once you have met the cap, Medicare will no longer pay, and you will be responsible for 100% of the charges (approximately \$124 per session).**

Any treatment you have received at another out-patient facility, even if it was for a different injury or diagnosis, applies to the therapy cap.

If you have supplemental or secondary insurance, they will be billed once Medicare has made a payment decision. You are responsible for 20% of the charges if you do not have supplemental or secondary insurance, or if they do not pay.

Please sign this form to indicate that you understand the above therapy cap and supplemental/secondary insurance information. Please ask questions if there is anything that you do not understand. Alternatively, you can call 1-800-MEDICARE with any questions regarding your Medicare coverage.

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Name

Date