MIAMI PHYSICAL THERAPY ASSOCIATES INC.
2869 SW 27 Avenue • Miami, FL 33133
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www.miamipta.com

MEDICARE

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone _____

Email: _____ Social Security Number: _____

Marital Status: Single Married Widowed Other Employment Status: Full Time Part Time Retired

Employer: _____ Occupation: _____

Employer Address: _____

Referred By Dr: _____ Next Dr. Appt: _____

Have you Received Physical Therapy Or Speech Therapy Elsewhere in 2014? Yes _____ No _____

If yes, where and for how long? _____

Is this injury covered by auto insurance, employer's insurance, or a legal case? Yes _____ No _____

Whom may we notify in case of an emergency? _____ Telephone: _____

SECONDARY INSURANCE CARRIER INFO:

INSURANCE CARRIER: _____

NAME OF INSURED: _____

POLICY NUMBER: _____

- I hereby consent to physical therapy treatment provided to me by Miami Physical Therapy Associates, Inc, and prescribed by my physician.
- I understand and agree that I am personally responsible for all fees for services rendered by Miami Physical Therapy Associates, Inc. to me or my dependants regardless of what my insurance covers.
- I authorize the release of any medical information necessary to process this claim.

_____ _____
Signature of Patient Date

_____ _____
Witness Date

TO OUR MEDICARE PATIENTS: **JANUARY 2014**

Please be advised that we are a Medicare Part B participating provider. What this means is that we accept Medicare's fee schedule as payment for our services. About 30 days after we submit your bills,
First Coast/Medicare will reimburse us directly for 80% of their fee schedule. You may be responsible for the remaining 20%, plus your 2014 deductible of $147.00 if you do not have a secondary form of insurance. Under no circumstances do we waive your deductible or co-payment as it is considered by the federal government as fraud.

For Medicare to pay for your treatments, you have to meet the following criteria:

1. You MUST HAVE a physician's referral given upon you physically being re-examined by your doctor every 30 days. It is your responsibility to physically be re-examined by your physician every 30 days. If you do not, Medicare will deny payment for those visits after the 31st day and we will then collect the entire visits fee from you.

2. You must be discharged from any home health care services prior to initiating outpatient physical therapy. Medicare will not pay for both home health care and outpatient care at the same time.

3. If you initiated physical therapy with an out of state prescription, you must present this office with a Florida MD prescription within 21 days of your first visit in order to be in compliance with our Florida Physical Therapy License.

The benefits in the Part B program have changed. It now specifies that there is a $1900 limitation for outpatient physical therapy in all settings per calendar year.

If your condition requires care beyond $1900, we will be happy to continue your care at our facility at the Medicare allowable fee schedule.

I acknowledge that I have read the above policy, and I understand that I am responsible for my 20% co-payment, any deductible not met, and for notifying Miami Physical Therapy Associates, Inc. if I have not met the above mentioned criteria.

_____ _____

Signature of Patient Date

We truly appreciate the opportunity to meet your physical therapy needs.

Medicare Patients

Have you had any Health Care Services provided in your HOME in the last 60 days? I.E. Therapy, Wound Care, Diabetic Care, etc.

YES NO

If yes, last date of service: _____

Name of agency: _____

Telephone number of agency: _____

I hereby authorize my home healthcare agency to release to Miami PT Associates, Inc. a copy of my Discharge Summary along with a copy of the Discharge paperwork that they sent to Medicare.

_____ _____

Signature of Patient **Date**

_____ _____

Witness **Date**

For Office Use Only

- ☐ Called Home Health Agency to Confirm Discharge Date
- ☐ Spoke to _____ at _____
  Name Time
- ☐ Patient discharged _____
  Date
- ☐ Patient will be discharged
- ☐ Confirmed with First Coast

Date: Name: Reference Number: