Medicare Insurance Information[1]

It is a patient's responsibility to know their Insurance benefit for PT services, as a courtesy our billing department will confirm policy benefits for our records and may review them with you.
Please ask if you have any questions or do not understand your insurance coverage.

Patient Name: ______________________________ Date__________________

Primary Insurance Physical Therapy Coverage? Yes No

Insurance Co. Name: ____________________ Phone#: ( ) __________ Insured's Name: ______________

ID # ____________________Group# _______ Insured's SS#: ______________ Insured's DOB: ___________

Relation: _________Insured's Employer: ______________________ Employer's Address: __________________

Deductible: _________________ Amt. Met: _____________ CoPay: ____________

Visit Limit: ____________ Auth Needed: ______ Auth Number: _________________________

Secondary Insurance Physical Therapy Coverage? Yes No

Insurance Co. Name: __________________ Phone#: ( ) ________ Insured's Name: ____________________

ID # ________________Group# ____________ Insured's SS#: _____________ Insured's DOB: ___________

Relation: ______Insured's Employer: __________________ Employer's Address: _________________________

Have you received Chiropractic or Physical Therapy treatment during your current insurance benefit period? Yes No When __________________ Where ___________________________________

Authorization for Payment

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this physical therapy office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this physical therapy office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me to be credited to my account. **However, I clearly understand and agree that I am personally responsible for payment for all services rendered me.** I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. Collection fees and/or interest fees may apply on any unpaid account balance.

By signing below, I acknowledge that I understand & agree to the insurance information that Active Recovery Physical Therapy has discussed with me today. I also agree to pay the deductible amount and any co-payments that are due at the time of my visit unless payment arrangements are made.

_________________________________ _____________________

Signature Date

[1] Active Fitness & Physical Therapy 436 Central Ave. Oak Hill, WV 25901 Phone: 304-465-3654 Fax: 304-465-8551

Medicare Information

Please Initial & sign Below

____ I understand that Medicare has a $185.00 deductible and covers only 80 % of the cost of Physical Therapy services and that unless I have secondary Insurance that will cover my deductible and the remaining 20% that I am responsible for the balance on my account.

____ I understand that Medicare has a $2040.00 cap per year on Physical Therapy services unless my diagnosis or condition requires continued treatment due to medical necessity.

____ I understand that I will be informed and given a choice to receive or refuse any recommended services not covered by Medicare and that I will be responsible for paying for any uncovered services I agree to.

As a courtesy, we will monitor the amount applied toward the PT Cap and inform you if you have reached the $2040.00 limit. If treatment is necessary beyond the cap, we will assess the medical necessity for the need to continue so that you are eligible for an exception to the cap.

It is customary to pay your Co pay when services are rendered. If you are unable to make full payments at each appointment we will accept a reduced payment and bill any remaining balance monthly. Payments may be made on your balance.

If you are retired, on disability or have limited income we have a sliding scale and may reduce or waive your deductible or copay. Please ask us for details.

Signature____ Date______________________________