



## MEDICARE PATIENT NOTICE

**Medicare Therapy Prescription:** Because of Medicare regulations, your prescription for therapy is valid for **90 days** from the date your doctor signs the prescription. In order to ensure uninterrupted therapy, we will send a report to your referring physician within 90 days from the date of your prescription, so that your doctor will be able to determine if continued therapy is needed.

**Home Health Services & Physical/Occupational Therapy:** Medicare will not cover out patient therapy services if you have home health service. In the past six months has anyone, other than your family member(s), performed the following for you?

Hygiene and Grooming: such as cutting nails and washing your hair **Yes:**\_\_\_\_\_ **No:**\_\_\_\_\_  
Nursing: such as injections (insulin), IVs, your bandage and wound care **Yes:**\_\_\_\_\_ **No:**\_\_\_\_\_  
Therapy: exercises and massage **Yes:**\_\_\_\_\_ **No:**\_\_\_\_\_

If Yes, please provide us with the following information:

Name of the home health agency: \_\_\_\_\_

Telephone number of the agency: \_\_\_\_\_

Date services ended: \_\_\_\_\_

**2008 Therapy Cap Summary:** If your diagnosis is not exempt, Medicare has placed a financial limitation of \$1,810.00 on the amount of therapy an individual can receive in 2008 from a private practice clinic. We will review the available options with you when you are approaching the cap.

Your Medicare plan may also have a deductible. We will inform you what your deductible is and how much of it you have met.

Have you received ANY outpatient physical therapy, occupational therapy or speech therapy since January 1, 2008? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, how many visits? \_\_\_\_\_

Have you been released from a hospital or Skilled Nursing Facility (SNF) within the past 30 days? \_\_\_\_\_ Yes \_\_\_\_\_ No If Yes, please provide us with the following information:

Name of facility: \_\_\_\_\_

Date of release from facility: \_\_\_\_\_

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My signature below indicates that I have read and understand the above information regarding the Medicare therapy cap and home health services, and have had all my questions answered.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reviewer:** \_\_\_\_\_ **Date:** \_\_\_\_\_