HUDSON VALLEY ORTHOPAEDIC & SPORTS PHYSICAL THERAPY
MEDICARE PAYMENT AGREEMENT

REFERRALS:

New York State law requires that all patients treated by a physical therapist must be referred by a medical doctor, podiatrist or dentist. The referral (prescription) must be currently dated and in writing. **Medicare requires that you see your referring physician at least once during the first 60 days of physical therapy treatment** and that the physician review and sign an established plan of care according to your needs not to exceed 90 days. Please allow sufficient time to obtain an appointment with your doctor prior to the expiration of your prescription in order to avoid interruption of your physical therapy treatments.

CHARGES & REIMBURSEMENT:

This office is a participating provider of Medicare services. We agree to accept as payment, **the Medicare approved amount for all covered services**. **Your charges per visit may vary depending upon the treatment you receive each visit. You are responsible for any deductible, co-payment / coinsurance amounts and items purchased in accordance with your insurance benefit plan/s.**

General Information on Therapy Cap:

Therapy caps are congressionally mandated financial limitations on outpatient occupational therapy, physical therapy, and speech-language pathology services, except for those services provided in the hospital outpatient setting.

Effective January 1, 2014, Medicare implemented a **combined financial limitation of $1920 for outpatient physical therapy and speech language therapy.** This implementation of financial **limitation ($1920)** will apply to **combined outpatient physical therapy and speech language therapy services rendered from January 1, 2014 through December 31, 2014.** (This **"therapy cap"** is an **annual** per beneficiary limitation.) **The $1920 limitation is applicable to the allowed incurred expenses. If you have already satisfied the Medicare Part B deductible ($147), the maximum amount payable by the Medicare program is $1536; that is 80 percent of the $1920 for PT (including speech language pathology.) You are responsible for paying the remaining 20% coinsurance unless you have coverage provided by a second insurance. (See 2nd Insurance information below.)**

SECOND INSURANCE: Medicare provides coordination of benefits with a number of insurance carriers. An updated list of these carriers is available from the office staff. These carriers provide an automatic electronic crossover to Medicare. **If you have this coverage, we will provide Medicare with the necessary information in order for your claim to be processed to your supplemental insurance company. If you do not have this type of secondary insurance or if you do not have any supplemental insurance, you will be responsible for paying the 20% coinsurance per visit /or any co-payment required by your second insurance. Please note: many second insurance carriers also have an annual deductible amount you will be responsible for paying. PLEASE CHECK YOUR BENEFITS.**

EXCEPTION PROCESS: Despite the Therapy Cap, Congress has provided an exception process for the Therapy Cap limit. All Medicare beneficiaries enrolled in Medicare Part B are eligible for an exception if they receive "medically necessary therapy" (therapy must be rehabilitative rather than maintenance) AND have or will exceed the cap. Please note: any therapy services provided above the "cap," in the absence of an exception from the cap, are not a Medicare benefit, making you (the beneficiary) financially liable for those services.

Additionally , Medicare has also imposed a combined physical therapy and speech therapy "threshold" of $3700, that if exceeded will require a manual therapy review and authorization prior to the continuation of any physical therapy treatment. **This office will advise you when your financial limitation of benefit is approaching the maximum allowable amount.

WAIVER OF LIABILITY:

Medicare may question **"the medical necessity"** of services rendered beyond the **"therapy cap"** (if applicable) or **beyond 12 - 18 visits** and subsequently deny payment for such treatment. You will be asked to sign a **waiver of liability**, accepting financial responsibility for each visit as outlined above, when your therapist believes that Medicare may question the medical necessity of your treatment. This "waiver" will advise you that Medicare may deny reimbursement for the treatment you have received.

Please complete the information requested on this form and return it along with your Medicare ID card and secondary insurance card (if applicable), to the front desk. PLEASE PRINT. (over)

DATE: _____

Patient's Name: _____

Last **First** **Middle**

Patient's Medicare # (HICN): _____

_____patient became eligible for Medicare coverage.

Month **Day** **Year**

• **IS MEDICARE THE PATIENT'S PRIMARY INSURANCE? Yes _____ No ____**

Is the patient's condition related to:

- **Employment (current or previous)? Yes ____ No ____**
- **Auto accident? Yes ____ No ____**
- **Other accident? Yes No**

•Is the patient's physical therapy required as a result of, or subsequent to, a related hospitalization? Yes__ No __

If yes, please provide your hospital admission_____ and hospital discharge _____.

Month Day Year

Month Day Year

- **Has the patient received any physical therapy at home? Yes___ No ___**

• Does the patient have any Group Health Plan through a current or former employer? Yes___No ___

If YES, does the employer have less than 20 employees? Yes___ No ___

• Does the patient have any Group Health Plan through a family member's current or former employer? Yes___ No ___

If YES, does the employer have less than 20 employees? Yes___ No ___

• Is the patient disabled and have insurance coverage either by a Large Group Health Plan from work, or coverage by a family member who is working? Yes___ No ___. If YES, does the employer have 100 or less employees? Yes___ No ___

•Has the patient received physical therapy and/or speech language therapy at another facility during this year? Yes__ No __

•If yes, please indicate where and approximate dates_____

• Does the patient have any other health insurance secondary to Medicare? Yes__ No __

If yes, please complete the following:

Insured's Name: _____

Last **First** **Middle**

Insured's Address: _____

Street **City** **State** **Zip Code**

Insured's Employer (present or former - if provider of insurance): _____

If retired, date of retirement: _____

Insured's date of birth: _____ **Sex: male _____ female_____**

Month Day Year

Insured's relationship to the patient: self _____ spouse _____ child____ other____

Insurance plan name: _____

Policy #: _____ **Group #:** _____

- **I agree to pay weekly any portion of my bill that my insurance will not reimburse directly to Hudson Valley Orthopaedic & Sports Physical Therapy.**
- **I understand I am financially responsible for payment in full, if for any reason my insurance does not cover the charges for my physical therapy treatment as outlined in this payment agreement.**
- **If my account is forwarded to a collection agency as a result of non-payment, I will also be responsible for any fee the collection agency imposes on my account.**
- **I will notify the office staff if temporary financial problems arise that may affect my account, in an effort to make arrangements agreeable to all parties.**

Patient's Signature: _____

Legal Guardian Name (please print): _____

Last **First** **Middle**

Legal Guardian Signature: _____

Relationship to Patient: _____