New Pelvic Health Patient Registration Forms Packet

Please print the following forms and fill out and/or sign those with an asterik (*) and bring with you completed to your Initial Evaluation.

I. Welcome Letter

II. Patient Information and Consent to Treat Form*

III. Medical (General) History Form*

IV. Pelvic Health History Form*

V. Attendance Policy Form*

VI. Financial Policy Form*

VII. HIPAA Acknowledgement Form*

VIII. Understanding Your Medicare Coverage Form*
    (only if your primary insurance is Medicare or Medicare Advantage)
Dear Patient,

**Welcome to DPT Sport!** We are excited that you have chosen us to take care of your physical therapy and wellness needs. All of our physical therapists have advanced doctoral degrees in physical therapy, in addition to specialist certifications, and multiple years of experience treating a variety of medical conditions. Research has shown that physical therapy is effective in restoring movement, relieving pain, strengthening muscles, improving balance, as well as enhancing overall function and preventing further injury. Our team here at DPT Sport is dedicated to providing you with exceptional care from your initial call in to our clinic to schedule your Initial Evaluation until your last day at discharge, “Graduation Day”. Our friendly staff is here to help you understand your insurance benefits and answer any additional questions that you may have about your treatment and/or associated billing. Your first appointment is scheduled for _________________ at __:_______.

This Initial Evaluation with us usually lasts about an hour and will consist of a comprehensive evaluation and assessment, education regarding your diagnosis and customized treatment plan as well as the start of your treatment. We will make every effort to address all of your questions and concerns.

To help us provide the best care possible, you will need to bring the following to your Evaluation:

1) *Completed* New Patient Registration forms **needed prior to beginning evaluation**
2) Physician referral (if necessary for reimbursement by your insurance carrier)
3) Your insurance card(s)
4) Drivers license (or government-issued picture ID if no license)
5) Any lab/test results (i.e., x-ray, MRI, CT reports) relevant to your current condition

Please wear or bring comfortable clothing and tennis shoes that will allow therapist to evaluate the involved region (i.e., shorts for knee or hip injuries, tank top for neck or shoulder injuries, etc.) and allow you to move freely to perform various activities and/or exercises. A washroom is available for clothing changes, however please secure all personal items; DPT Sport is not responsible for any lost or stolen items.

Our clinic is located in the fitness center of the King-Bruwaert Community in Burr Ridge, Illinois. Our address is 6101 S. County Line Rd, in Suite 57. Please call us at (630) 230-9565 if you need directions or have any additional questions.

Thank you again for choosing DPT Sport!

Warmest Regards,

Christine Klody
Founder and President-DPT Sport
Doctor of Physical Therapy
PATIENT INFORMATION

Today’s Date: __________________________

Patient Name: Last_________________ First__________________ MI ____                             Male ☐ Female ☐

Prefers to be called__________________ Date of Birth___________ Age ______ Marital Status:     S     M     D    W

Address______________________________ Apt #______ City__________________ State_______ Zip___________

Home Phone______________________ Cell Phone______________________ Work Phone_____________

Where do you prefer to receive calls?    Home ☐ Cell ☐ Work ☐   Email ________________________________

How do you prefer to receive appointment reminders?    ☐ Text Message (standard rates apply)    ☐ Email

How did you hear about DPT Sport? ________________________________

Occupation____________________ Employer Name______________________________

Employer Address_________________________ Employer Phone_________________ Full-time / Part-time / Other

Emergency Contact: Name____________________ Relationship__________________ Phone__________________

Referring Physician Name (if have referral)______________________________ Phone__________________

Date of next appointment with physician___________________

Primary Care Physician Name_________________________ OR (circle) No Physician

May we contact your physician?  Yes ☐ or  No ☐ Phone__________________

Injured Body Part_________________________ R ☐ L ☐ N/A ☐ Date of Injury/Symptom Onset__________

Have you had any Physical or Speech Therapy within the current calendar year? ________________________

Auto Accident? ☐ Yes ☐ No    If Auto, what state? ___________ Another Type of Accident? ☐ Yes ☐ No

Work-related? ☐ Yes ☐ No    Attorney Involved? ☐ Yes ☐ No    Case Manager_________________________

Consent to Treat, Authorization and Release:

I hereby authorize and consent to medical examination and treatment as deemed necessary and appropriate for my condition or illness in the judgement of my physical therapist, to be performed by my physical therapist. I certify that the information provided by me for purposes of payment for this treatment is, to the best of my knowledge, complete and accurate. I authorize the release of any information to third party payors, government agencies, and/or entities involved in billing and collection in order to process my claims. I authorize and request my insurance company to pay all assigned insurance benefits directly to DPT Sport, PC on my behalf. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature_________________________________________________     Date:___________________
MEDICAL HISTORY FORM

Patient Name__________________________________________________ Date__________________
Age_________ Height_________ Weight_________ Are you: ☐Right-handed ☐Left-handed

Brief description of current symptoms:__________________________________________________
____________________________________________________________________________________

Currently working? ☐Yes ☐No Occupation: ______________________ Work-related Injury? ☐Y ☐N
Leisure activities, including exercise routine:________________________________________________

Do you use an assistive device for mobility? ☐Y ☐N With whom do you live?____________________
Rate your general health: ☐Excellent ☐Good ☐Fair ☐Poor

Drink alcohol? ☐Y ☐N How often?_________ History of chemical dependency? ☐Y ☐N

Check all of those that apply to your current condition:
☐Aggravation of pre-existing/recurring injury ☐Motor vehicle accident ☐Fall
☐Sports injury ☐Causes unknown ☐Lifting injury ☐Other

Date of injury/Symptom onset: _______________ Have you ever had these symptoms before? ☐Y ☐N

Have you received treatment for these symptoms? ☐Y ☐N If yes, what type:________________________

Have you had physical or speech therapy (outpatient clinic or home health) within the last calendar year? ☐Y ☐N

What type of testing has been done on this body part(s): (circle all that apply)
☐X-ray ☐MRI ☐CT Scan ☐Other Results:____________________________________________________

What have you been doing to decrease your symptoms?____________________________________________

Symptoms getting: ☐Worse ☐Same ☐Better Causing difficulty sleeping? ☐Y ☐N

On a scale of 0 (no pain) to 10 (emergency room), what is your pain level:

Currently?______ At worst in past two weeks?______ On average in past two weeks?______

Aggravating factors (Positions and/or activities that make your symptoms worse):
1.________________________________________ 2.________________________________________ 3.________________________________________

Easing factors (Positions and/or activities that make your symptoms better):
1.________________________________________ 2.________________________________________ 3.________________________________________

(Please turn over for page 2)
Check any of the following activities that you have difficulty with due to your symptoms:

☐ Lifting  ☐ Dressing  ☐ Reaching  ☐ Housekeeping  ☐ Cooking  ☐ Negotiating stairs
☐ Child care  ☐ Bending  ☐ Sit to stand  ☐ Yard work  ☐ Driving  ☐ Shopping  ☐ Exercising

Body Chart:
Please use the diagram to the right to indicate where your symptoms are located. Using the key below, indicate the type of symptoms experienced:

xxxxxxx Shooting/Sharp pain
oooooo Dull/Aching pain
/////////// Numbness
******* Tingling

Do you currently have or do you have a history of any of the following:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>Allergies</td>
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<td>Anemia</td>
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<td>Anxiety</td>
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<td>Arthritis</td>
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<td>Asthma</td>
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<td>Autoimmune disorder</td>
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<td>Cancer</td>
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<td>Cardiac conditions</td>
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<td>Cardiac pacemaker</td>
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<tr>
<td>Chemical dependency</td>
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<td>Circulation problems</td>
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<tr>
<td>Currently pregnant</td>
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<tr>
<td>Depression</td>
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<td>Diabetes</td>
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<tr>
<td>Nausea/Vomiting</td>
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<tr>
<td>Hypoglycemia</td>
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<tr>
<td>Ulcers/GI Issues</td>
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</tbody>
</table>

If “Yes” to any of the above, please explain and give approximate dates. Also, describe any other conditions not listed above:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Fall History
Have you sustained an injury as a result of a fall in the past year? ☐ Y ☐ N
Two or more falls in the last year? ☐ Y ☐ N
Do you feel unsteady or at risk for falls? ☐ Y ☐ N
**Surgical History**

Body Region: ____________________ Surgery Type: ____________________ Date: ____/____/____

Body Region: ____________________ Surgery Type: ____________________ Date: ____/____/____

Body Region: ____________________ Surgery Type: ____________________ Date: ____/____/____

Body Region: ____________________ Surgery Type: ____________________ Date: ____/____/____

Body Region: ____________________ Surgery Type: ____________________ Date: ____/____/____

**Current Medications**

☐ Currently not taking any medications

Drug: ______________ Dosage: _____ Frequency: _____ Route: _______ Reason Taking: __________

Drug: ______________ Dosage: _____ Frequency: _____ Route: _______ Reason Taking: __________

Drug: ______________ Dosage: _____ Frequency: _____ Route: _______ Reason Taking: __________

Drug: ______________ Dosage: _____ Frequency: _____ Route: _______ Reason Taking: __________

Drug: ______________ Dosage: _____ Frequency: _____ Route: _______ Reason Taking: __________

Drugs: __________________________________________

**If more space is needed to include all of your medications, please attach a list of additional medications**

Please list any serious and/or recent hospitalizations: ___________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Have you RECENTLY experienced any of the following (check all that apply)?

☐ Numbness or Tingling  ☐ Weight loss/Gain
☐ Constipation  ☐ Heartburn/Indigestion
☐ Fever/Chills/Sweats  ☐ Fainting
☐ Muscle weakness  ☐ Difficulty swallowing
☐ Diarrhea  ☐ Difficulty with balance
☐ Nausea/Vomiting  ☐ Shortness of breath
☐ Falls  ☐ Dizziness/Lightheadedness
☐ Headaches  ☐ Changes in bowel and/or bladder function
☐ Cough  ☐ Fatigue

Is there any other pertinent information about your present health that we should know about?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
PELVIC HEALTH HISTORY

Patient Name ______________________________ Evaluation Date _____________________________

Describe the main problem(s) that brought you in today:
__________________________________________________________________________________

When did your symptoms begin? ____ (circle) months/years ago

Surgical History:

<table>
<thead>
<tr>
<th>Surgery for your back/spine</th>
<th>Y N</th>
<th>Surgery for your bladder or prostate</th>
<th>Y N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hysterectomy or other pelvic surgery</td>
<td>Y N</td>
<td>Abdominal Surgery</td>
<td>Y N</td>
</tr>
</tbody>
</table>

If answered “Y” to any of the above, please provide greater detail (i.e. procedure date, etc):
__________________________________________________________________________________

Have you EVER experienced any of the following?

<table>
<thead>
<tr>
<th>Frequent urinary tract infections</th>
<th>Y N</th>
<th>Constipation</th>
<th>Y N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pelvic pain</td>
<td>Y N</td>
<td>Recurrent diarrhea</td>
<td>Y N</td>
</tr>
<tr>
<td>Blood in urine</td>
<td>Y N</td>
<td>Pain during or after sexual activity</td>
<td>Y N</td>
</tr>
<tr>
<td>Urethral stricture</td>
<td>Y N</td>
<td>Pain with pelvic or prostate exam</td>
<td>Y N</td>
</tr>
<tr>
<td>Endometriosis (females)</td>
<td>Y N</td>
<td>Pelvic cancer</td>
<td>Y N</td>
</tr>
<tr>
<td>Sexually Transmitted Infections/Disease</td>
<td>Y N</td>
<td>Sexual abuse or trauma</td>
<td>Y N</td>
</tr>
</tbody>
</table>

If answered “Y” to any of the above or have any other conditions not listed, please provide greater detail and approximate date(s):
__________________________________________________________________________________

BLADDER SYMPTOMS:

Do you experience the following related to your CURRENT bladder function:

Urinary leakage with coughing, sneezing, lifting, laughing, or exercise? Y N

Urinary leakage while sleeping? Y N

Urinary leakage associated with urgency, causing you to rush to the bathroom? Y N

Urinary leakage at rest, or unassociated with any activity? Y N

Overwhelming urge to urinate or need to urinate excessively? Y N

Strain to pass urine, or have difficulty initiating a stream? Y N

Dribble urine post-urination? Y N

Go to the bathroom “just in case” when you are near a bathroom? Y N

Hover or squat over the toilet to urinate? Y N

Pain with urination? Y N

Wear protective pads for incontinence? Y N

If yes, how many pads per day? ______ What size pad: __________________

How many glasses of fluid do you drink daily? ______ How many are caffeinated? ______

How many times do you urinate during awake hours? _____ During sleep hours? ______

How frequently are you experiencing leakage? _____ times per day/week (circle)

(OVER)
BOWEL SYMPTOMS:

Do you experience the following related to your CURRENT bowel function:

- Regular constipation? Y N
- Feeling of incomplete emptying? Y N
- Often strain or hold your breath during bowel movements? Y N
- Ever have to use your fingers to help evacuate a bowel movement? Y N
- Pain during or after bowel movements? Y N
- Bleeding when having a bowel movement? Y N
- Frequent diarrhea? Y N
- Pass gas without meaning to? Y N
- Leakage of stool (fecal incontinence)? Y N

How often do you have a bowel movement? ________ times per day/week (circle)

Is your stool typically hard or soft? ____________________________

FOR FEMALES ONLY (skip to the next section if male):

Obstetric/Gynecologic History:

- Are you sexually active? Y N
- Are you pregnant or attempting pregnancy? Y N
- Are you postmenopausal? Y N
- If yes, for approximately how many years? ______

Number of pregnancies: ________________

Number of vaginal deliveries and dates: ________________________________

Number of cesarean deliveries and dates: _______________________________

Please circle any of the following you have experienced related to childbirth:

- Episiotomy
- Forceps/Vacuum Delivery
- Vaginal Tearing
- Prolonged Labor

Have you EVER or do you CURRENTLY experience have any of the following?

- Prolapse, or feeling of something falling from the vagina Y N
- Painful periods Y N
- Pain during or after sexual activity Y N
- Other significant history (please describe): ________________________________

FOR MALES ONLY (skip if female):

Are you currently sexually active? Y N

Have you EVER or do you CURRENTLY experience have any of the following?

- Pain in the penis, testicles, scrotum, groin, or perineum Y N
- Erectile Dysfunction Y N
- Pain in the penis, testicles, scrotum, groin, or perineum Y N
- Symptoms related to enlarged prostate Y N
- Painful erection or ejaculation Y N
ATTENDANCE POLICY

In order to achieve successful outcomes in physical therapy here at DPT Sport, the three following prerequisites are necessary: regular attendance in therapy, open communication with your therapist, and consistent follow-through with your integral home exercise program.

Out of respect for your therapist, his/her valuable time as well as other patients’ desires for similar appointment times with your therapist, 24-hour notice via phone call is required to cancel or reschedule any scheduled appointment. Failure to provide 24-hour business day notice (business day ending at 5 pm) will result in a $50.00 late cancellation or no show fee (this fee will be payable before continuing physical therapy/prior to your next visit and is not be covered by insurance).

Patients or clients who miss three consecutive appointments or have two no show/no calls or two late cancellations (or generally erratic/inconsistent attendance) will be automatically discharged. All missed visits are documented in the patient’s medical record; this information is shared with the referring physician (and insurer if work comp patient, which could jeopardize your claim and/or prolong/terminate any benefits that you may be entitled to. Please note: all missed WC visits must be rescheduled to prevent issues with your claim/case).

Patients must be on time for their scheduled appointment. Patients arriving more than 15 minutes late may be asked to reschedule their appointment or may have to wait until his/her next scheduled appointment.

Patients are welcome to bring a family member with them to the Initial Evaluation. However, as a courtesy to other patients, please do not bring children, spouses, or other family members into the common treatment area.

I, (Print Patient Name) ____________________________________________, have read DPT Sport’s Attendance Policy as stated above and understand that my cooperation and active participation directly relates to the success of my therapy program.

In signing below, I agree to the terms and conditions set forth by DPT Sport in this document for treatment/services as well as payment.

_______________________________________________       __________________
Signature of Patient (or Legal Guardian/POA)                Date
Thank you for choosing DPT Sport as your physical therapy provider. Please take the time to read through this document, as your clear understanding of our financial policy is important to our professional relationship and ultimately, your care here at DPT Sport.

Please understand that timely payment for your physical therapy treatment is important. Insurance is a contract between you and your insurance carrier. We strongly encourage you to contact your insurance carrier to determine what coverage they provide for physical therapy. As a courtesy to you, we will verify your physical therapy benefits and also submit all claims for services rendered to your insurance provider(s), but we cannot guarantee what your insurance carrier(s) will pay. In order for our office to do this, you must provide us with all of the necessary and accurate personal and insurance information. In addition, please notify us immediately if any changes in your insurance or coverage are made.

DPT Sport is an in-network provider for Medicare and Blue Cross Blue Shield. (Note: If your primary insurance carrier is not one of these, you will be responsible for out-of-network rates). You will be responsible for the remaining balance that your primary insurance carrier (and secondary insurance carrier if applicable) does not pay. In addition, please be aware that some, or perhaps all, of the services provided may be considered not medically necessary by your insurance provider; you will be responsible for these charges. Most medical equipment and supplies are not considered a covered entity in your insurance plan.

Please note the following:

All co-pays and deductibles are due at the time of service in order to abide by your insurance contract. Payment of your patient balance is due in full at the time of service. Monthly statements will be sent out from our billing department, billing any charges not paid at the time of service. Payment for all statement balances is due within 30 days of the statement date. If any portion of your account balance exceeds 60 days, you will be responsible for this amount plus interest herein at 2% per month.

DPT Sport, PC accepts payment by cash, check, and the following credit cards: Visa, MasterCard, American Express, and Discover. The card must be physically present to charge. Alternatively, patients may request electronic invoices to be emailed to them, where they can then follow the secure link to pay online via the company’s Square credit card processing system. Please advise our Front Desk Coordinator if you would like to do so.

Thank you for understanding our financial policies. If you have any questions or concerns, please do not hesitate to contact Christine Klody (President of DPT Sport/Doctor of Physical Therapy) at (630)230-9565.

I understand that I am ultimately financially responsible for payment of all services (all outstanding balances) that are not paid by my insurance carrier(s). Should my account be referred for collection, I will be responsible to pay for the costs of collection, including legal fees.

Patient Name (Please Print) __________________________________________________________

(If applicable) Legal Guardian/POA Name (Please Print) ________________________________

Signature of Responsible Party __________________________________ Date: _____________
Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by DPT Sport, PC (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice that sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have the right to request a copy of the Privacy Notice, upon which time the Practice will immediately provide this to me. This Privacy Notice is also located on the Practice’s website online for review under the ‘For Patients’ section.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: DPT Sport, PC, 6101 S. County Line Rd, Suite 57, Burr Ridge, IL 60527, Attention: Compliance Officer.

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing. I request the following restrictions be placed on the Practice’s use and/or disclosure of my health information (leave blank if no restrictions):

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

DPT Sport, PC and its employees may leave voicemails regarding my physical therapy care at any of the phone numbers that I have provided to them on my new patient registration forms.

I authorize that DPT Sport, PC and its employees have my permission to discuss my personal health care information relevant to my care here at DPT Sport with the below named individual(s) who play a role in my daily life including, but not limited to, my family, friends, or/caregiver(s):

By signing this form, I acknowledge that I have reviewed an executed copy of this acknowledgement and a copy of the Practice’s Policy Notice and agree to the Practice’s use and disclosure of my protected health information for treatment, payment and health care operations.

Printed Name of Patient (or POA/Representative if applicable)_________________________ Patient’s Date of Birth_________________________  
Signature of Patient (or POA/Representative if applicable)_________________________ Date_________________________  
Relationship to Patient_________________________
UNDERSTANDING YOUR MEDICARE COVERAGE

To: Our Medicare (Part B) Patients

Beginning in early 2018, Congress eliminated the limits on how much Medicare (CMS) pays for (Part B) outpatient therapy services in one calendar year (formerly known as the "Medicare Therapy Cap"). However, for CMS to pay for your services, the law requires your physical therapist to confirm that your therapy services are medically necessary throughout the duration of your care, both in your medical record and on your insurance claims to CMS.

It is your physical therapist that decides whether skilled physical therapy is medically necessary (not Medicare and not your physician). If your therapist deems that skilled physical therapy is still medically necessary by Medicare standards, he/she will document this in your medical record and on your claims, thus communicating this need to CMS, and continue on with your treatment/plan of care. As a Medicare requirement, we do need to know and it is your responsibility to let our team know how many Medicare Part B (outpatient) therapy dollars (physical and/or speech therapy) have been used in the current year so that we may include this in our documentation. CMS tracks, but does not cap, the dollars that you use in therapy. As long as we have been given accurate information regarding any therapy dollars that may have been used earlier in the year, CMS should be able to process and pay your claims expediently without issues.

At the time when your therapist feels skilled physical therapy is no longer medically necessary, he/she will give you two options to choose from:

1. You may elect to be discharged with an independent home exercise program (HEP).
2. You may elect to continue with physical therapy, but will then be changed over to a self-pay patient (responsible for full balance/charges at DPT Sport's self-pay rates); in this case, you will need to sign a CMS form accepting responsibility for paying out of pocket for therapy services that are not deemed medically necessary per CMS standards.

Please note: Your Medicare deductible ($198 for 2020) is due at the time of service. After you have met your Medicare deductible (for Traditional Medicare Part B plans), CMS will pay 80% of your outpatient physical therapy charges. If you have a secondary insurance, please check with that specific plan to determine what percentage of the remaining balance that this secondary payor will pay.

There are also numerous Medicare Advantage primary insurance plans (that you may have purchased to replace your Traditional Medicare Part B plan), all with vastly different coverage benefits. We will verify these for you as a professional courtesy. These plans do follow CMS guidelines for medical necessity as described above. All deductibles and co-pays for these plans are due at the time of service.

Co-insurance amounts are due upon our practice receiving your Explanation of Benefits (EOB) (which you should also receive from your insurance payor), signifying that your insurance payor has fully processed your claim(s).

Although we are here to assist you as best we can, it is ultimately a patient’s responsibility to know your insurance coverage benefits as well as what benefits are still remaining. We have provided this summary of the Medicare coverage for informational purposes. Although many providers do not provide this information, we wanted to take the time to make sure you understand your Medicare coverage. Please feel free to call our office with any questions.

______________________  ____________________
Patient Name (and Signature or POA signature if applicable)    Date