Patient_____

Dear Patient,

Effective January 1, 2012 Medicare imposed limits on benefits paid for outpatient Physical Therapy services provided in private practice setting. Medicare has limited coverage to $1,880.00 per calendar year. This amount is divided between Medicare payment and patient payment. Medicare will pay $1,504.00 and your responsibility would be $376.00 if all benefits are used. If you maintain a secondary payer the $376.00 may be covered. We have estimated that this cap will allow you to receive up to 10-12 visits in our facility. You will be informed that your benefit is ending at least one visit prior to reaching the visit limit.

The benefit for Physical Therapy is cumulative for the year. This includes any Physical Therapy or Speech Therapy services provided to you this year. If you have exhausted your benefits with another provider or with us earlier this year you will be responsible for any part of your bill in excess of the $1,880.00 limit. Medicare has informed us that they may not be able to verify your use of benefits. It is therefore your responsibility to determine if you have Physical Therapy benefits available for your treatment with us.

This coverage limit pertains to independent Physical Therapy offices. You may choose to receive additional treatment at a hospital or continue Physical Therapy with us on a self-pay basis if continued treatment is indicated.

Please choose **one** of the following statements:

_____ I **have** received Physical Therapy or Speech Therapy treatment in a non-hospital setting this year.

_____ I **have not** received Physical Therapy or Speech Therapy treatment in a non-hospital setting this year.

_____ (initial) I understand that if I previously used my Medicare benefits for Physical Therapy or Speech Therapy treatment that I will be responsible for treatment provided in excess of my annual benefit.

_____ (initial) If you have had **Home Health Care** over the past 60 days Medicare may deny payment for Physical Therapy

By signing below I am stating that I understand the limits of my Medicare coverage for Physical therapy services and assume financial responsibility for non-covered care.

_____

Signature Date

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