Dear Patients,

Please note your copay, co-insurance or contracted rate towards your deductible is due at the beginning of each appointment. Once your insurance has processed your claims and decided the amount allowed, you may haye an additional bill sent to you from our billing company.

Please note we call on your benefits as a courtesy and it is your responsibly to know your coverage and pay for your portion of the services we provide. We thank you in advance for your cooperation as our team works hard to make sure you have quality care at our office.

-Caldwell Physical Therapy

CALDWELL PHYSICAL THERAPY
AND SPORTS REHABILITATION

MEDICARE 2024 CONFIRMATION OF BENEFITS

Company Name: _____ Date: _____

Patient Name: _____

As you begin your course of treatment with us, we would like you to be acquainted with our policies and procedures *regarding payment*:
This is a summary of your benefits as quoted by a representative of your insurance company and not a guarantee of payment. Eligibility and benefits will be determined at the time your claims are processed.

Insurance Carrier Primary: Medicare ID#: _____
Secondary: _____ ID#: _____

Deductible Amount Primary: Medicare $240.00 Has it been met? ☐ yes, how much $ _____ ☐ no

Secondary: _____ Has it been met? ☐ yes, how much $ _____ ☐ no

Your policy covers: Medicare pays 80% of $2230.00 annual combined maximum for physical and speech therapy
Secondary:

Estimated Patient Copayment/Portion: _____

Limitation and/or Exclusions: Medicare $2230.00 annual combined maximum for physical and speech therapy. Services over $2230.00 up to $3000.00 threshold requires that the therapy be medically necessary for the treatment of your condition through 12/31/2023

Has any been used? ☐ yes, how much $ _____ ☐ no

____1. If you have insurance you are still responsible for payment of services rendered, regardless of any coverage. We will make every effort to keep track of your total visits, but it is your responsibility to be aware of the limitations of your policy. **You are hereby notified in advance that you will be financially responsible in full for any services beyond those allowed or denied for any reason by your insurance carrier.** Should you require treatment or procedures beyond the benefit offered by your insurance company, you may negotiate with them for additional coverage. Any reports, documentation and/or phone calls beyond those considered usual and customary will be subject to a fee.

____2. We will make every effort to verify your coverage with your carrier and inform you of your deductible and copayment responsibilities. We verify benefits as a courtesy to our patients and we are at no time to be held responsible if incorrect information has been obtained. Please remember that the information we get from your carrier is only an estimate, and we cannot be sure of the exact amount until we submit a claim and receive an Explanation of Benefits. Your insurance company will process your claims as in or out of network according to your insurance policy.

____3. Once your deductible, if any, is met, we will collect only your estimated copayment and will bill your insurance carrier for the balance. We will make every reasonable effort to assist in expediting insurance payment; however, you will be responsible for negotiating any eligibility or payment disputes directly with your insurance carrier.

____4. If your insurance company has not acknowledged any portion of your account within 60 days, the balance is due and payable in full. You will be responsible for the entire debt incurred for services rendered. Accounts remaining outstanding after sixty (60) days will be subject to a 1.5% per month finance charge. Unpaid accounts will be turned over to collection.

____5. ***You are responsible for paying your copayments at the time of each visit.*** If you cannot do this, you must make special financial arrangements with our business office. Failure to meet your financial responsibilities may result in termination of your treatment.

____6. There will be a charge of $50.00 for NO SHOW appointments or cancellations with less than 24-hour notification. You will be personally responsible for any cancellation fees.

____7. Please note you are personally responsible for payment for any supplies you receive such as: electrodes, theraband, gym balls, etc… Payment is due at the time of service.

This year have you received any physical and/or speech therapy services in Part B Skilled Nursing Facility (SNF), Comprehensive Outpatient Rehabilitation Facility (CORF), Outpatient Rehab Facility (ORF), Private Practice, Home Health Agency, and/or Hospital Outpatient Departments, Critical Access Hospitals (CAH)? ☐ Yes ☐ No

If yes, how many visits/how much? _____

Are you enrolled or receiving Home Health? ☐ Yes ☐ No

Ifyes specify dates: _____

I have read and fully understand all of the above information and hereby agree to comply as outlined.

_____ _____
Patient Signature Date

A. Notifier/Practice Name: _____

B. PatientName:_____ **C. IdentificationNumber:**_____

2024 Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
☐ 97012 Mechanical Traction	☐ Over Medicare Standard of Treatment	$: _____
☐ G0283 Electric Stim	☐ Not Covered procedure code	
☐ 97035 Ultrasound	☐ Not Medically Necessary_____	
☐ 97110 Therapeutic Ex	_____	
☐ 97112 Neuro Re-Ed	☐ Patient is enrolled under Home Health	
☐ 97116 Gait Training	☐ Maintenance program, no measurable progress being made	
☐ 97124 Massage	☐ Other: _____	
☐ 97140 Manual Therapy	_____	
☐ 97530 Therapeutic Activities	☐ PT & Speech Services combined $2230.00 Medicare Annual Maximum	
☐ 97535 Activities of Daily Living	☐ PT & Speech Services combined over $2230.00 up to $3000.00 are subject	
☐ 97033 Iontophoresis	to the Medicare Review Process for medical necessity through 12/31/2023	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about yourcare.
- Ask us any questions that you may have after you finishreading.
- Choose an option below about whether to receivethe **D.**_____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box foryou.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-paysor deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare wouldpay.

H. Additional Information: _____

_____

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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