



Physical Therapy Services

Upon referral from a physician, Physical Therapy services are provided in this clinic by a licensed Physical Therapist or Physical Therapy Assistant. These services may be billed under a separate provider other than the physician, with charges that are specific to Physical Therapy. Physical Therapists are required to conduct their own independent evaluation and establish a plan of care in order to bill for their services. Please note that your bill may indicate the supervising physician on the premises and not your therapist's name. When a physician is on site and available for this supervision and immediate feedback we may bill the Therapist's services incident to the physician meaning that your bill may indicate the name of the supervising physician on the premises instead of your therapist's name. Some insurance companies allow more when these services are incident to which means you may have a slightly higher coinsurance amount.

You will receive charges on your bill for a Physical Therapy evaluation and in addition any and all types of Physical Therapy treatment you have received.

We will make every attempt to pre-authorize your physical therapy services with your primary insurance company. You will be responsible for any pre-authorization requirements for secondary or tertiary coverage as well as any third party such as auto accidents. There may be a separate co-pay charge for Physical Therapy depending upon your insurance. If you have a co-pay for your doctor's visit, it is possible that you will have a co-pay for Physical Therapy services. Also, some insurance plans have limitations on the number of therapy visits they will cover.

Prior to your next therapy appointment (if you have one) you should check with your insurance on therapy coverage, limitations and co-pays. Any co-pays should be taken care of the same day that you receive therapy services.

Short-term cancellation or failure to show for your appointment creates an undue burden and increases the cost of care to other patients. If you cancel with less than 24 hours notice or do not show for your appointment three times you may not be rescheduled for Physical Therapy.

I have read and understand the above statement. I understand that I will be responsible for any and all charges regarding Physical Therapy that are not covered by my health insurance.

Patient Name: _____
Please Print

Patient/ Guardian Signature: _____ Date: _____

Relationship to Patient: _____

Complete Only for Minor Patients

Authorization to Treat Minor Patient in the Absence of Parent/Guardian

I, _____, the parent and legal guardian of _____, consent to the physical therapy evaluation and treatment. I understand my child may be treated in my absence if an established Plan of Care has been established with a physical therapist. I understand this authorization is valid through the course of the established Plan of Care and I have the right to revoke this authorization at any time by writing to Missoula Bone & Joint Physical Therapy & Sports Medicine. I understand if my child's Plan of Care changes then I will be required to attend his/her appointment to discuss changes with the therapist.

Name of Parent/Guardian

Date

Signature of Parent/Guardian

Date

PATIENTS COVERED BY MEDICARE, PLEASE SEE REVERSE SIDE



FOR OUR MEDICARE PATIENTS:

As of January 1st 2009, Medicare has imposed an annual payment limit (cap) of \$1,840.00 on Physical/Speech Therapy and \$1,840.00 on Occupational Therapy services. These limits apply to all Physical/Speech Therapy and Occupational Therapy services provided as an outpatient except for outpatient hospital therapy and the emergency room. It also includes therapy received from Home Health Care and in a Skilled Nursing Facility.

How does this affect you? Medicare will cover expenses for therapy services up to \$1,840.00 for the current year. You, the patient, will be responsible for any expenses incurred for Physical/Speech Therapy or Occupational Therapy over this limit. This includes any therapy services you have received at another clinic, through Home Health or in a Skilled Nursing Facility in the current year.

We are committed to providing the best service for you and will do our best to make sure you do not exceed the cap, but it is ultimately the patient's responsibility to monitor their financial liability. There are some exceptions to the therapy caps available. Your therapist will help you determine if your condition will qualify should that need arise.

Please initial each statement below if you have NOT received the services listed during the current year.

____ Outpatient Physical/Speech Therapy except for outpatient hospital.

____ Outpatient Occupational Therapy except for outpatient hospital.

____ Home Health Physical/Speech therapy.

____ Home Health Occupational Therapy.

____ Therapy in a Skilled Nursing Facility.

Please sign below verifying that you have been informed of the outpatient therapy limitations and that any expenses incurred for Physical Therapy or Occupational Therapy beyond \$1,840.00 will be your financial responsibility.

Patient Name: _____
Please Print

Patient Signature: _____ Date: _____