In Motion Physical Therapy

Disclaimer for Medicare Patients

Home Health:

Have you had any Health Care Services provided in your home in the last 60 days (i.e.; Therapy, Wound care, Diabetic care, etc.)? ☐ Yes ☐ No If yes, Date of last service____________

Name of Agency: _______________________________ Telephone Number of Agency_______________________

If you had Home Health Services: You must be discharged from any health care services prior to initiating outpatient physical therapy.

I authorize my home healthcare agency to release to IN MOTION PHYSICAL THERAPY a copy of my discharge summary.

Other Services:

Have you received Physical Therapy or Speech Therapy elsewhere in this current year? ☐ Yes ☐ No

If yes, where did you receive therapy? ____

Other Insurance:

Is this injury covered by: ☐ Auto Insurance ☐ Employer' Insurance ☐ Legal Case

Do you have a Secondary Insurance? ☐ Yes ☐ No If yes, please present at 1st visit.

Patient Responsibility:

It is your responsibility to be physically re-examined by your physician every 90 days.

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to In Motion Physical Therapy for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, and its agents any information needed to determine these benefits or the benefits payable for related services."

X____

Authorized Signature Date