

Patient Name: _____

ADVANCE **BENEFICIARY NOTICE OF NONCOVERAGE (ABN)**

NOTE: If Medicare doesn't pay for **Physical Therapy treatment** listed 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 **Physical Therapy treatment listed** below.

Additional physical/occupational therapy because:

____ of the 'maintenance' nature of your care

____ the duration / frequency of your care has exceeded or will exceed what Medicare considers reasonable for your diagnosis and that the delivery of additional services is not essential to your recovery.

X Any services or related items provided over the 2010 physical/occupational therapy cap of \$1860.00 are not covered. (see attached notice)

____ **Modality/Procedure** _____ because this treatment is not considered medically necessary for your condition.

____ **Supply** _____ Medicare does not pay for this item.

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **Physical Therapy treatment** 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.

OPTIONS: Check only one box. We cannot choose a box for you.

OPTION 1. I want the **Physical Therapy treatment** 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-pays or deductibles.

OPTION 2. I want the **Physical Therapy treatment** 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 **Physical Therapy treatment** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

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 will also receive a copy.

Signature:	Date:
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS

There are items and services for which Medicare will not pay.

- Medicare does not pay for all of your health care costs. Medicare only pays for covered benefits. Some items and services are not Medicare benefits and, therefore, Medicare will not pay for them.
- When you receive an item or service that is not a Medicare benefit, you are responsible to pay for it, personally or through any other insurance that you may have.
- The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself.
- Before you make a decision, you should ask for an explanation from your therapist and you should also for an estimate of the cost of the service or item.

Medicare will not pay for:

- Any services or related items over \$1,860.00 provided by physical or speech therapy for the entire year of 2010. Occupational therapy is allowed the same amount for the same period. The reason Medicare will not pay is because of legislation that placed a financial limit on those services
- Medicare considers any services that 'typically' would be provided by physical, occupational or speech therapist to be included in this \$1,860.00 'cap' even if they are not provided by a therapist, for instance if they are provided in a doctors office.
- Medicare has made:
 - An exception to the \$1,860.00 'cap', which is for services provided by a hospital outpatient rehabilitation department. These services do not have a financial limit
 - Some exceptions to the cap which are based on your condition (diagnosis) or other environmental issues; these have very specific medical necessity requirements and must meet all of Medicare's criteria for an exception

Patient or Authorized Representative's Signature/Date

(Signature only indicates that this notice has been received per Medicare guidelines)

Patient or Authorized Representative's Signature/Date

(Signature indicates that the above person is agreeing to pay for services over \$1,860.00)



Irving Orthopedics and Sports Medicine Physical Therapy Department

Medicare Questionnaire

Patient Name: _____

Date: _____

Medicare ID#: _____

Date of birth: ____/____/____

1. Is the patient retired? No Yes

2. Is this injury a result of an auto accident?

No

Yes - fill out: Insurance Name: _____

Address: _____

Phone #: (_____) _____ - _____

Policy #: _____

3. Is the patient enrolled in any other health insurance policy primary to Medicare (i.e. Secure Horizons HMO, Secure Horizons Direct, ect...)?

No

Yes - please notify front desk

4. Is the patient receiving services from a Home Health Agency for **any** medical condition (related or unrelated to this injury you are being treated for today)?

No

Yes - please notify front desk

5. Is the patient currently a resident of a Skilled Nursing Facility?

No

Yes - please notify front desk

By signing below, I certify that the information stated above is current and correct. If any of this information above changes during the course of treatment, you recognize an obligation to immediately notify our front office. You may be responsible for any balance or non-payment that occurs resulting from late or lack of notification.

Patient/Guardian Signature

Date signed

Office Use Only

Home Health Agency Information:

HHA: _____

Ph#: _____

Reason for treatment: PT / OT / ST / other

Therapist/RN: _____

D/C date: _____ Confirmed by: _____

If the primary carrier of the other health insurance policy (not Medicare) is **NOT** retired and this policy is offered through their current employer, ask the following question:

** Does the employer that sponsors the group health plan (GHP) employ 20 or more employees?

No - Medicare is primary and the GHP is secondary

Yes - The GHP policy is primary to Medicare.



Irving Orthopedics & Sports Medicine

INITIAL SELF-EVALUATION

Name: _____ Age: _____ Date: _____

Occupation: _____ Last day worked (if applicable): _____

Have you had surgery for this condition?: YES / NO If yes, on what date? _____

Please take a moment to fill out the following questions as accurately as able. This information will greatly improve my ability to help you with your condition. Please don't forget to sign at the end. If you need assistance with this form, please contact the front desk.

PRESENT CONDITION:

A. Please mark your primary complaint:

Loss of: function motion strength

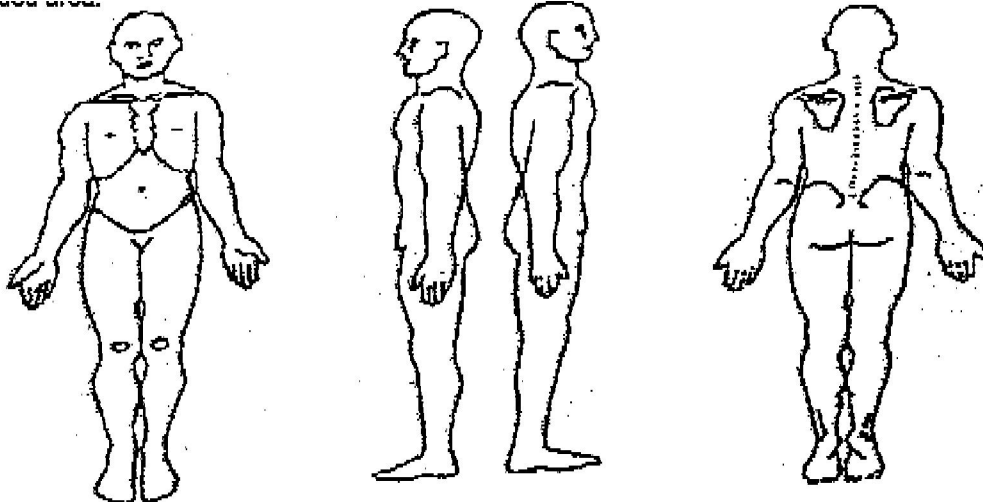
Pain with: walking sleeping standing sitting sports reaching lifting work duties

Other: _____

B. Please explain the condition that brought you to Physical / Occupational Therapy or why your doctor sent you here.

On what date did this occur? If there was no injury, for how long have you had these symptoms?

C. Please shade in area or areas where you are experiencing pain/symptoms. Then draw a line from the words below to the shaded area on body where you feel that symptom. Feel free to use more than one description for each shaded area.



- Sharp
- Dull
- Ache
- Stabbing
- Numbness/Tingle
- Burning
- Weakness
- Stiffness
- Radiating
- Burning
- Severe
- Moderate

D. Please list each symptom area above and rate it on the scale provided.
(0 = No pain, 5 = moderate pain, 10 = most severe pain (need to go the emergency room)

<u>SYMPTOMS</u>	<u>SEVERITY</u>
1. _____	0 1 2 3 4 5 6 7 8 9 10
2. _____	0 1 2 3 4 5 6 7 8 9 10
3. _____	0 1 2 3 4 5 6 7 8 9 10

E. Overall your symptoms are: ()getting better ()worsening ()staying the same?

F. What makes your symptoms worse?

- () Sitting how long? _____ () Standing how long? _____
() Bending (direction) _____ () Walking how long? _____
() Other – please specify _____ () Reaching direction? _____

G. What eases your symptoms?

- () Sitting () Standing () Ice () Heat
() Rest () Elevation () Other – please specify _____

H. Please circle how often you experience the symptoms: ()constant ()comes & goes ()certain times of day

()Certain positions Other _____

I. How much do your symptoms interfere with your activities?

Daily Activities of Living:

- () None () Rarely () Often () Most of the time () Always

Extra-curricular:

- () None () Rarely () Often () Most of the time () Always

J. Are you taking medication for THESE symptoms? YES / NO

If yes, what and how much?

K. Have you received any injections for these symptoms? YES NO If yes, on what date(s)?

The injection provided: () Good relief () Some relief () No relief

L. What tests have been performed? () X-ray () MRI () EMG () CT () Bone scan () other _____

What are the test results? _____

M. Do you have any follow up testing scheduled? YES NO If yes, when? _____

() X-ray () MRI () EMG () CT () Bone scan () other _____

N. When is your next scheduled follow up with your doctor who requested this therapy? _____

PAST HISTORY of SIMILAR SYMPTOMS:

A. Have you ever had the same kind of symptoms as you have now? ()YES ()NO If no, skip to next section.

B. If Yes, when? _____

C. How often do they recur? _____

D. How is this episode different?

- () Severity
() Irritability
() Nature
() Location

E. What made them better before? _____

PAST MEDICAL HISTORY:

- A. Any other accidents or injuries for which you saw a doctor? ()YES ()NO If yes, please list:

- B. ANY surgeries? (Heart, abdominal, any bone or joint or ligament or other?) ()YES ()NO If yes, please list:

- C. Other medications or problems diagnosed by a physician (Include Name of MD)? ()YES ()NO

D. Have you HAD or do you NOW HAVE any of the following:

- | | |
|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Blood disorder* | <input type="checkbox"/> Short of breath |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Infectious disease* |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Bowel / bladder problems |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Unexplained weight/energy loss* |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hearing or vision difficulty |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Emotional problems |
| <input type="checkbox"/> Sleeping difficulty | <input type="checkbox"/> Smoker – packs/day_____ |
| <input type="checkbox"/> Stroke /blood clot | <input type="checkbox"/> Currently pregnant |
| <input type="checkbox"/> Severe/frequent headaches | <input type="checkbox"/> Other _____ |

• please explain/describe: _____

E. Are you currently under the care of a physician, psychiatrist or other healthcare professional in addition to the one prescribing your Physical / Occupational Therapy? ()YES ()NO If so, Who?

F. Have you ever had any Physical / Occupational Therapy or other body work prior to this occasion? YES NO
If yes, please explain

G. Is there anything else you would like me to know about? If so, please explain.

H. What are your expectations to gain through therapy?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Decrease pain | <input type="checkbox"/> Regain strength | <input type="checkbox"/> Regain motion | <input type="checkbox"/> Return to specific activity |
| <input type="checkbox"/> Improve Function:_____ | | <input type="checkbox"/> Other_____ | |

Thank you for taking the time to tell me about your symptoms. I look forward to discussing your symptoms with you.
Please sign below.

Patient Signature

Date

Reviewed / Signed by Therapist:

Date



Irving Orthopedics & Sports Medicine

Acknowledgement of Review of Notice of Privacy Practices

I have received and review this facility's Notice of Privacy Practices, which explains how my private health information will be used and disclosed. I understand that I am entitled to receive a copy of this document. By signing this form, I consent to the use and disclosure of my protected health information for the purpose of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent. A photocopy or fax of this consent is as valid as the original.

In addition, I authorize the release of information to the individuals/entities identified below by name and relationship:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Print Patient Name

Signature of Patient/Guardian

Date

Facility Representative Signature

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of review of our Notice of Privacy Practices, but were unable to do so for the following reason:

_____ Patient/Guardian refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ Other (please specify) _____

Facility Representative Signature