Patient Information Sheet (Medicare)

Name _____ ☐**M** ☐**F** **DOB:**_____ **Age:** _____

Home Address_____ City _____State:____ Zip _____

Home PH#:_____ Cell/Other PH#: _____

Email Address: _____ Work PH#: _____

Occupation:_____ Employer: _____

Referring Provider / Referral Source: _____

☐ Married ☐ Divorced ☐ Single ☐ Minor/Child ☐ Widowed ☐ Separated

Emergency Contact: (name, phone # & relationship) _____

Social Security Number (last 4 digits): __XXX-XX-_____

☐ **Have you had any other OT/PT/Speech/Chiro this year**? If so, how many? _____

☐ **Are you currently receiving <u>ANY</u> home health services**? _____

☐ **Primary Language (if other than English)** _____

☐ **You do not need to complete the insurance section(s) if we photocopy your insurance card(s).**
☐ **Red Flag Rules** require that we now <u>photocopy</u> and verify a Driver's License/Photo ID as proof of identity.

Primary Insurance CompanyName: _____

ID/Subscriber Number# _____ **Group No #:**_____

Address: _____

Name of **Responsible Party** if different than Patient _____

DOB: _____ **SS#:** _____ **Employer**: _____

Secondary Insurance Carrier _____

ID/Subscriber Number# _____ **Group#:** _____

Name of **Responsible Party** if different than Patient _____

DOB: _____ **Relationship to Patient:** _____

Medicare:
Medicare as a primary insurance covers 80% of the adjusted cost of treatment. Medicare will be billed first, and then the remaining 20% will be billed to your secondary insurance if applicable. Payment for services rendered is your responsibility. Payment for a Medicare deductible that has not been met and estimated co-insurance (if you do not have a secondary carrier) <u>IS DUE AT THE TIME OF SERVICE</u>. Any remaining balance that is due after insurance payment will then be billed to you. We are NOT a contracted provider with CENCAL.

FYI: Medicare requires a prescription for therapy services signed by your physician every 30 days. Medicare has a cap for occupational therapy services at $1920 for the calendar year of 2014. Medicare will only cover therapy services that are working towards functional goals. It will not cover a maintenance program.

****Twenty-four hours notification is requested when canceling an appointment. Thank you!**
(In the event of multiple cancellations or No-Shows, you ***will*** be charged a $25 fee for missed appointments.)

I hereby state that the information I have provided is true and correct to the best of my knowledge.

Signature: _____ Date: _____