Home Health Care History

Have you recently received Home Health Care for any reason? (Circle one): Yes / No

If **YES**: date of discharge from Home Health Care:____________________
Name of Home Health Care Agency: __________________________________
Medicare does not reimburse for home health care and outpatient physical therapy simultaneously. Therefore, I understand that if I receive Home Health Care and outpatient physical therapy services at the same time, it is my responsibility to pay Valdosta Physical Therapy, Inc. for treatment.
I have read and understand the terms and conditions of Medicare.

Patient Signature:____Date:____

Medicare Billing Information

The Physical Therapists of Valdosta Physical Therapy, Inc. are " Medicare Participating Providers of Outpatient Physical Therapy." What does this mean to you? It means that:

- You are responsible for, and must pay the deductible to Valdosta Physical Therapy, Inc.
- **You are responsible for any items or supplies (compression garments, thera-band, splints, etc.) not covered by Medicare.**
- We will not charge you more than the amount Medicare allows for the services we provide for you.
- Of the amount that Medicare "allows" Medicare will pay 80% of what they deem medically necessary; you will be responsible for the remaining 20%. If your Medicare is an HMO or PPO your deductible may be different
- If you have insurance in addition to your Medicare, tell the receptionist which of your policies is the primary (pays first) and which is secondary (pays second). For most, Medicare will be primary. Please be prepared to clarify this for us.
- Medicare checks will be mailed directly to the clinic. You will not receive a bill form us until Medicare has paid.

Patient Signature:____Date:____

Informed Consent

I consent to receiving physical therapy services, which are deemed medically necessary by my referring and/or primary care physicians or physical therapists. I authorize the release of medical information to my referring physician and insurance company. I hereby assign all medical benefits to be paid directly to Valdosta Physical Therapy, Inc.

Print Name:________________________Patient Signature:______________________________________Date:___________