Western New York Physical & Occupational Therapy Group, PLLC

TO OUR MEDICARE PATIENTS

Welcome to **Western New York Physical & Occupational Therapy Group**. We thank you and your physician for choosing our practice for your rehabilitation services.

About your Prescription: A written a prescription from a NYS licensed medical doctor, osteopathic doctor, physician assistant, nurse practitioner, or podiatrist is required by Medicare in order to begin treatment.

***About your Plan of Care*:** After your evaluation, a PT/OT treatment plan of care will be sent to your physician for authorization as well as re-certification of your therapy treatment plan of care every 90 days. Medicare requires your physician to sign the certifications as soon as possible for treatment to remain uninterrupted.

***About Medicare's Rehabilitation Benefit*:** Physical/Occupational Therapy (PT/OT) is a benefit that is billable through your Medicare Part B policy. Congress has imposed two financial limitations on your outpatient therapy services, which are in effect through 12/31/2018. The 2018 limits per beneficiary per year are:

1. Therapy CAP (explanation attached)
   - $2,010 Physical and Speech Therapy combined, and
   - $2,010 Occupational Therapy
2. Therapy Threshold – Maximum of $3700 per year.

We will make every effort to keep you informed as you approach these limitations.
Deductibles and co-insurance are the beneficiary's financial responsibility.

If you have a secondary insurance policy, please be sure to notify the office.

Have you received any therapy in the year 2018?

Physical and/or Speech Therapy Yes _____ No _____
Occupational Therapy Yes _____ No _____
If yes, when and by whom? _____

Medicare may not cover your outpatient therapy services if a Home Care Agency is providing services in your home during the same time period. To help us determine whether Medicare will cover your outpatient services, please read and answer all the questions below.

- Are you presently or in the past year received any Homecare services in your home?
  Yes _____ No _____ If yes, when and by whom? _____

- Do you have someone coming to your home to assist you with bathing, dressing or housekeeping?
  Yes _____ No _____ If yes, who? _____

- Does someone come to your home to carry out exercise or practice your walking?
  Yes _____ No _____ If yes, who? _____

- Do you receive any speech or swallowing exercises in your home?
  Yes _____ No _____ If yes, who? _____

- Does a nurse come to your home to check your health, medicines, blood pressure or heart?
  Yes _____ No _____ If yes, who _____

Please feel free to contact our Billing Department at 684-0400 if you have any questions about your Medicare billing. You can monitor your available benefit by calling **1-800-MEDICARE.**

Your signature below certifies that you have read and understand the information provided regarding your Medicare coverage as it pertains to PT/OT. Thank you.

PATIENT SIGNATURE_____ **DATE** _____/_____/_____