|  |  |
| --- | --- |
| **Backway’s Physical Therapy****250 S. McCormick****Prescott, AZ 86303-4714****(928) 777-8050 • [fax (928) 443-9029]****2019 Medicare Coverage & Non-covered Services:**1. Medicare uses a calendar year "maximum" of **$2040** for outpatient Physical Therapy (PT) combined with any Speech Therapy (SLP).
2. **Although we do our best to only provide and bill for services that Medicare covers**, Medicare does have the right to deny coverage for any services you receive from any provider.
3. If Medicare denies coverage, your supplemental policy usually will not make payment on your account.
4. If you reach the $2040 "maximum" **Threshold**, any services provided beyond this must be medically necessary and justifiably requiring the services of a licensed Physical Therapist.
5. Many health insurances, including Medicare, do **not** pay for supplies, orthotics, heel lifts or ‘maintenance’ services not requiring PT skills.
6. Unbeknownst to Backway’s PT, in some very rare cases, a portion or all of the services you receive may not be covered or may be considered “not reasonably necessary” by Medicare.
7. If you should meet your maximum of **$2040**, or if Medicare and/or your supplement denies payment for  **any** services, or portion thereof, while you are being treated at our office, then **you will be responsible** for the charges incurred for PT services.
8. **A statement of your current paid balance** can be obtained from our office at your request. If you have any questions concerning this policy, please do not hesitate to ask.

 ***I have read and fully understand the contents of this policy.*** ***I recognize that Medicare and my supplemental insurance may not pay for all the treatments I receive. I know I am responsible for all services received, and I agree to pay for the services rendered to me which are not covered by Medicare and/or my Supplemental Insurance.******Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_*** | Signature Date1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15.         |

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(Medicare Sign-In Form Page 1 of 1)*