<u>Notice of Exclusions from Medicare Benefits</u>
<u>NEMB</u>

Notice: As of January 1, 2013, the Health Care Finance Administration under direction of the United States Congress reinstated the cap on Rehabilitation Services, Adjusted for inflation this cap is now **$1,900.00** for Physical Therapy **per calendar year.**

The purpose of this form is to inform you of this in advance that this $1,880.00 is based on what Medicare pays (allowable amount), not on what we at Movement Arts Physical Therapy, charge. **<u>With that in mind we anticipate that therapy would be covered from 12-18 visits depending on per visit charges.</u>**

If you have received therapy (PT) at any other outpatient location other than at a hospital based rehab department for any reason in the same calendar year, those visits are included in your 12-18. Failure to tell us about previous outpatient PT therapy visits may cause you to exceed this cap and be personally liable for all charges incurred beyond the $1,900.00 amount.

Though you may elect to continue to receive care at our facilities, you become personally liable for charges incurred after an allowable amount of $1,900.00. **Please ask us to help you if you do not fully understand this.**

If you have a secondary or supplemental plan, they may or may not pay for additional fees once Medicare monies have been exhausted. **Please check with your plan to determine their individual policies.** We will make every effort to check as well prior to your first visit. It should be noted that all deductibles will continue to apply.
It will be our policy to keep track for you those allowable charges incurred at our center so you can make informed decisions.

I **<u>have</u>** received rehabilitation services since January 1, 2013 ____________ (initial)

I **<u>have not</u>** received rehabilitation services since January 1, 2013 ____________ (initial)

By signing this form you are acknowledging that you have been informed of this new Federal Policy and desire to receive rehab services at Movement Arts Physical Therapy.

Patient Name: ________________________________*Date:* ______________________

Patient Signature: _____________________________*Date:* ______________________

MEDICARE CAP EXCEPTION AGREEMENT

I, ________________________________, acknowledge that as of this date, ______________________________, am aware that I have exceeded the 2013 Medicare Cap of $1,900.00.

By this acknowledgment I am aware that I may be responsible for charges incurred should Medicare deny payment due to lack of medical necessity.
Patient Signature:________________________________Date:______________________