

ALL PATIENTS PLEASE READ AND SIGN BELOW

I, consent to treatment and authorize the use of this signature on insurance claims pertinent to physical therapy treatments received at Performance Physical Therapy. I understand that as a courtesy, Performance Physical Therapy will bill my insurance company directly, but that I am personally responsible for any co-pays, deductible, or balances remaining after insurance consideration.

Date: _____
Signature of Patient or responsible party (if patient is a minor)

MEDICARE PATIENTS PLEASE COMPLETE THIS SECTION

IF YOU ARE A MEDICARE PATIENT PLEASE COMPLETE THE FOLLOWING...

LIFE TIME AUTHORIZATION

Provider's Name: Performance Physical Therapy, Inc.
2075 Barkley Blvd, Suite 200, Bellingham, WA 98226 or
1616 Cornwall Ave, Bellingham, WA 98225

Patient's Name: _____

Patient's Medicare #: _____

Patient's Address: _____

This authorization is good until revoked/rescinded by patient.

I request that payment under the medical insurance program be made to the provider named above on any bills for services furnished to me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

Date: _____ Patient's Signature: _____

Effective January 9, 2004, the Centers for Medicare & Medicaid Services (CMS) changed its rules to allow Medicare patients to receive up to 60 days of physical therapy (*with that 60 days starting on the **initial** physical therapy visit*) **before they are required** to visit their physician for re-evaluation.

Example, if your initial appointment at Performance Physical Therapy is January 1, and your treatment(s) go beyond 60 days (February 29) you **must again be seen** by your referring physician **and obtain another prescription** which would be **good for an additional 30 days**

We encourage you to call your Medicare Part B insurance company if you have any questions or comments regarding this mandate.

Please sign below to confirm that this has been explained to you.

Medicare Patient's Signature: _____