CENTRE OF PHYSICAL REHABILITATION
2301 COIT RD SUITE B
PLANO, TEXAS 75075
PHONE (972) 599-9191
FAX (972) 599-2323

MEDICARE REGISTRATION AND CONSENT FORM

Patient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____

(PLEASE ANSWER THE FOLLOWING QUESTIONS BELOW, THEY MAY AFFECT YOU MEDICARE BENEFITS)

HAVE YOU RECEIVED ANY PHYSICAL THERAPY TREATMENTS IN 2016? YES / NO; HOW MANY VISITS? _____

ARE YOU CURRENTLY RECEIVING HOME HEALTH SERVICES? YES / NO

MEDICARE NOTICE

OUTPATIENT PHYSICAL THERAPY IS **NOT** COVERED IF YOU ARE RECEIVING ANY HOME HEALTH SERVICES.
PLEASE ADVISE OUR OFFICE IF YOU ARE **CURRENTLY RECEIVING HOME HEALTH SERVICES** OR
IF YOU **BEGIN RECEIVING HOME HEALTH SERVICES** AFTER STARTING OUTPATIENT PHYSICAL THERAPY.

WAS YOUR CONDITION A RESULT OF A MOTOR VEHICLE ACCIDENT? YES / NO

WAS YOUR CONDITION A RESULT OF AN ACCIDENT INVOLVING A THIRD PARTY? YES / NO

PLEASE EXPLAIN: _____

MEDICARE NOTICE

PLEASE BE ADVISED THAT IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS MEDICARE MAY NOT COVER YOUR TREATMENT AT THIS FACILITY AND YOU WILL BE FINANCIALLY RESPONSIBLE!

DOB: _____ Home Phone: _____ Secondary Phone: _____
Social Security Number: _____ Marital Status: SINGLE MARRIED WIDOWED DIVORCED
Primary Care Physician Name: _____ Phone: _____
Person to Contact in Case of Emergency: _____
Phone: _____ Relationship: _____
Secondary or Supplemental Insurance: YES / NO Insurance Name: _____
Are you or your spouse working? YES / NO Are you eligible for group insurance benefits? YES / NO
If yes, please give employer information below:
Insurance: _____
Policy Number: _____ Group Number: _____
Any Other Insurance Name: _____
Policy Number: _____ Group Number: _____

MEDICARE NOTICE

PLEASE BE ADVISED THAT MEDICARE REQUIRES THAT YOU SEE YOUR PHYSICIAN EVERY 30 DAYS IN ORDER TO RECEIVE COVERAGE FOR TREATMENT. IN ADDITION, MEDICARE HAS A YEARLY CAP AMOUNT FOR PHYSICAL THERAPY OF $1,940.00.

I hereby state the Information listed above is accurate and I have read and understand the Medicare notifications. I authorize treatment and the release of any medical or other information necessary to process my insurance claims and I have been advised of the HIPPA policies verbally and in written form.

Patient Signature: _____ Date: _____