

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_

## For our Medicare Patients

We would like to inform our Medicare patients that each year Medicare implements an annual deductible, a cap and, most recently, a threshold for physical, occupational and speech therapy. If you are unaware of these guidelines, please ask our front desk or contact Medicare directly.

**Is a health care provider or agency coming into your home and providing medical services, assistance with household chores, personal hygiene, dialysis, drawing blood, etc. (otherwise known as Home Health Care)?**

Yes

No

**IN THE LAST 6 MONTHS has a health care provider or agency come into your home to provide medical services, assistance with household chores, personal hygiene, dialysis, drawing blood, etc. (otherwise known as Home Health Care)?**

Yes

No

If you answered yes to either of the questions above, this may affect how and where you receive your therapy treatment. Your treatment may have to be coordinated through your Home Health Care provider. Please list the agency/provider below that provided you with Home Health Care so we can determine the appropriate course of action.

**Please list your Home Health Care provider:**

**Agency Name:** \_\_\_\_\_

**Phone Number:** ( \_\_\_\_\_ ) \_\_\_\_\_

I understand the above statements and allow Chautauqua Physical & Occupational Therapy to contact the Home Health Care provider listed above.

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For Office Use Only:

Date of Eval: \_\_\_\_\_