

MRPT Physical Therapy, LLC

Patient name: _____

Medicare Number: _____

About your Medicare Benefits and Patient Responsibility

Your treatment and well-being is our primary concern, and we do not want you worrying about any potential insurance problems. **If you have any financial concerns or hardship with your Medicare coverage please talk to us.**

The following are some facts you should be aware of regarding your Medical Benefits for Physical Therapy

- **MRPT Physical Therapy, LLC** is a participating provider of Medicare. Since we are a participating Medicare provider we will handle all billing to Medicare and any secondary insurance
- **Medicare will assign any insurance benefits directly to us.**
- **Medicare requires you to satisfy a yearly deductible (\$135 in 2008)** before they will begin paying benefits. Medicare will deduct \$135 from the first claim they receive each calendar year. Unless you have satisfied your annual deductible with another physician's office you are responsible to pay your \$135 deductible to us.
- After your deductible is satisfied **Medicare will reimburse us 80% of their standard fee** for Physical Therapy services. Therefore your payment responsibility is 20% of the standard Medicare fee for Physical Therapy. **Medicare have a Financial cap (\$1,810 for 2008) for Out Patient Physical Therapy Services which will cover you for 16 treatments per year. Unless you have additional insurance coverage you will be responsible for payment of any treatments in excess of the Medicare cap.**
- Many patients have **Secondary Insurance Coverage** (AARP, United Healthcare, CIGNA, GHI etc), which may cover all, or a portion of, your 20% responsibility.

Understanding Medicare Benefits for Physical Therapy can be difficult, **if you have any concerns please ask us for further advice.**

Medicare Assignment: (in order that Medicare pay us directly for your Physical Therapy treatment)

I request that payment of authorized Medicare Benefits be made on my behalf to MRPT Physical Therapy, LLC (Provider number Q5WJL1) for any services furnished to me by that provider. I have read the information listed above regarding my Medicare Benefits and understand my patient responsibility.

This authorization is in effect until I choose to revoke it.

Signature: _____ Date: _____