MISSOULA Bone & Joint Physical Therapy & Hand Therapy

Therapy Services

Upon referral from a physician, therapy services are provided in this clinic by a licensed Physical Therapist, certified Occupational Therapist, or a Physical Therapist Assistant (under the direction and supervision of a licensed Physical Therapist). These services may be billed under a separate provider other than the physician, with charges that are specific to Physical Therapy/Occupational Therapy. Therapists are required to conduct their own independent evaluation and establish a plan of care in order to bill for their services.

Therapists Billing Incident To the Physician: Please note that your bill may indicate the supervising physician on the premises and not your therapist's name. When a physician is on site and available for this supervision and immediate feedback we may bill the therapist's services incident to the physician, meaning that your bill may indicate the name of the supervising physician on the premises instead of your therapist's name. Some insurance companies allow more when these services are "incident to" which means you may have a slightly higher coinsurance amount.

Pre-authorization and Co-pays: We will make every attempt to pre-authorize your therapy services with your primary insurance company. You will be responsible for any pre-authorization requirements for secondary or tertiary coverage as well as any third party such as auto accidents. There may be a separate co-pay charge for therapy depending upon your insurance. If you have a co-pay for your doctor's visit, it is possible that you will have a co-pay for therapy services. Also, some insurance plans have limitations on the number of therapy visits they will cover. Prior to your next therapy appointment (if you have one) you should check with your insurance on therapy coverage, limitations and co-pays. Any co-pays should be taken care of the same day that you receive therapy services.

Durable Medical Equipment (DME): Some DME items may not be covered by your insurance plan and you will be asked to pay in full at the time of service. All items are new when given and cannot be returned.

Self-Pay / Uninsured: Payment in full is required for all self-pay/uninsured patients and is required on the day of your appointment before being seen by the therapist.

No-Show Policy: As a courtesy to other patients on our waiting list, we do require notice if you are unable to attend your scheduled appointment. We request a notice in advance of 24 hours. Please be aware two "No Shows" within a rolling 12 month period may result in you being discharged from our therapy practice and no longer be able to reschedule any appointments for you. We have found this policy necessary to enforce due to high volume of appointment requests in our practice, and an increasing number of "No Shows".

I understand that achievement of successful outcome is dependent on my compliance to the treatment plan, prescribed exercise and activity, and keeping my scheduled visits. I consent to all treatments deemed necessary by my therapist.

Responsible parties will be responsible for an expenses incurred in collecting the amounts owed, including statement rebilling fees, attorney's fees, court costs, and/or the collection agency fee. Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a $25 fee per check returned. **I have read and understand the above statement and agree to this policy.**

Responsible Party Signature: _____ **Date**: _____

Responsible Party Name (please print): _____

Patient Name (if different from Responsible Party): _____

Complete Only for Minor Patients

Authorization to Treat Minor Patient in the Absence of Parent/Guardian

I, _____, the parent and legal guardian of _____, consent to the therapy evaluation and treatment. I understand my child may be treated in my absence if an established Plan of Care has been established with a therapist. I understand this authorization is valid through the course of the established Plan of Care and I have the right to revoke this authorization at any time by writing to Missoula Bone & Joint Therapy. I understand if my child's Plan of Care changes then I will be required to attend his/her appointment to discuss changes with the therapist.

_____ _____ _____

Name of Parent/Guardian Signature of Parent/Guardian Date

PATIENTS COVERED BY MEDICARE, PLEASE SEE REVERSE SIDE

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FOR OUR MEDICARE PATIENTS:

As of January 1st 2020, Medicare has imposed an annual payment limit (cap) of $2,080.00 on Physical Therapy and $2,080.00 on Occupational Therapy services. These limits apply to all Physical/Speech Therapy and Occupational Therapy services provided as an outpatient except for outpatient hospital therapy and the emergency room. It also includes therapy received from Home Health Care and in a Skilled Nursing Facility.

How does this affect you? Medicare will cover expenses for therapy services up to $2,080.00 for the current year. You, the patient, will be responsible for any expenses incurred for Physical/Speech Therapy or Occupational Therapy over this limit. This includes any therapy services you have received at another clinic, through Home Health or in a Skilled Nursing Facility in the current year.

We are committed to providing the best service for you and will do our best to make sure you do not exceed the cap, but it is ultimately the patient's responsibility to monitor their financial liability. There are some exceptions to the therapy caps available. Your therapist will help you determine if your condition will qualify should that need arise.

Please initial each statement below if you have NOT received the services listed during the current year.

____ Outpatient Physical/Speech Therapy except for outpatient hospital.

____ Outpatient Occupational Therapy except for outpatient hospital.

____ Home Health Physical/Speech therapy.

____ Home Health Occupational Therapy.

____ Therapy in a Skilled Nursing Facility.

Please sign below verifying that you have been informed of the outpatient therapy limitations and that any expenses incurred for Physical Therapy or Occupational Therapy beyond $2,080.00 will be your financial responsibility.

Patient Name: _____
Please Print

Patient Signature: _____ Date: _____