

**PROFESSIONAL REHABILITATION SERVICES
MEDICARE OUTPATIENT THERAPY QUESTIONNAIRE**

Important all questions MUST be answered if answered YES to a question

Previous Physical / Speech Therapy Questions:

Have you had Physical / Speech Therapy at any other outpatient clinic since January 1st of this year? Y / N
(If answered no proceed to Home Health / Skilled nursing questions)

If yes, what was the name of the office? _____

Was the Physical / Speech therapy you received at a hospital based outpatient clinic? Y / N

Was the Physical / Speech Therapy you received at a private physical therapy clinic? Y / N

If you are unsure please provide name and phone number of previous facility and we can call for you.

Name of PT Clinic: _____ Phone: _____

How many visits did you attend? _____

Home Health / Skilled Nursing Care Questions:

Have you had any Home Health Care Services or Skilled Care Nursing in the last 120 days for any problem (not just Physical Therapy)? Y / N (if no stop here, read disclaimer and sign bottom of form)

If yes, what Company? _____ Phone _____

When did you start? _____ Therapist / Nurse Name: _____

When were you discharged? Date _____ (If you have discharge papers please provide a copy for our files)

****Medicare will NOT pay for outpatient physical therapy services at our clinic if you are currently having or start home healthcare / skilled nursing services while having outpatient PT services at PRS. You need to be fully discharged from your home healthcare / skilled nursing agency in order to start or continue to receive out-patient physical therapy and for Medicare to pay for it.****

I understand it will be my responsibility for any balance not paid by Medicare due to attending Outpatient Physical therapy and Home Health and/or skilled nursing at the same time and not notifying Professional Rehabilitation Services of the event prior to or while attending outpatient physical therapy.

I agree I have read and agree to the policies mentioned above:

Patient Signature (Seal) _____ Date _____

Office Only: Checked form for all information Y/N - I Called HH Agency to verify Common Medicare Working File D/C date.
Initials: _____ Date Called: / / Verified with HH rep /agency _____ / _____ D/C Date with MCE is: / /