A. Notifier: Clawson Physical Therapy

___ 1075 Fulton Ave, Suite A, Sacramento, CA 95825

___ 6915 Elk Grove Blvd. Elk Grove, CA 95758

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage
(ABN)

NOTE: If Medicare doesn't pay for **D. Physical Therapy** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D. Physical Therapy** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Physical Therapy	If you are receiving Home Health services for any reason, Medicare will not pay for Out-patient services concurrently.	$125 per visit

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. Physical Therapy** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D. Physical Therapy** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CLAWSON PHYSICAL THERAPY

1075 Fulton Avenue, Suite A
Sacramento, CA 95825
916.488-4000
916.488-4005

6915 Elk Grove Blvd., Suite A
Elk Grove, CA 95758
916.684-3000
916.684-3003

Medical History

Personal Information

First Name:	Init:	Last Name:	
Date of Birth:	Social Security #:		Marital Status: ☐Married ☐Single ☐Widow
Street Address:			
City:	State:	Zip Code:	
Home Phone:	Cell Phone:		
Email Address:			
Spouse/Caregiver Name:			
Spouse/Caregiver Home Phone:	Cell Phone:		

Insurance Information

Financial Responsible Party Name:			☐ Check if Self
Financial Responsible Party Street Address:			
City:	State:	Zip Code:	
Primary Insurance:	ID#	Group#	Copay Amount:
Secondary Insurance:	ID#	Group#	Copay Amount:

***Please provide copy of insurance cards**

Medical Doctor Information

Prescribing Doctor Name:		Phone: FAX:	
Address:	City:	State:	Zip:
NPI:			

Office use only

Case Title: ICD10:

CLAWSON PHYSICAL THERAPY

Medical History

Current injury/illness:	Date of onset: Date of Surgery: (if applicable):

Prior Hospitalization? ☐ From: / / to / / at hospital.
Prior SNF stay? ☐ From: / / to / / at SNF.

Are you currently receiving **In Home Physical Therapy**? ☐ Yes ☐ No. If you had home health this year, please list the name of the agency:

_____.

Have you had **Outpatient Physical Therapy** for this issue this year?

When?	Where?

Check all that you have had or still have:

☐Stroke ☐High Blood Pressure ☐Hip Replacement L or R ☐Knee Replacement L or R ☐ Fracture(s)
☐Cancer ☐Respiratory Problems ☐Heart Problems ☐Pacemaker ☐Parkinson's
☐Diabetes ☐Seizures ☐Food Allergies OTHER: _____

Height_____ Weight _____ BP _____/_____

Check all that apply

Is the patient having difficulty walking? ☐ Yes ☐ No Pain with walking? ☐ Yes ☐ No

Does the patient use a : ☐ cane ☐ walker ☐ wheelchair ☐ any type of brace

Does the patient have any of the following at home: ☐steps ☐stairs ☐ramp

Does the patient need assistance with transfers? ☐ Yes ☐ No How much? ☐ 1 person ☐ 2 person ☐ Hoyer

How did you hear about CLAWSON PHYSICAL THERAPY?

_____

I certify that all of the above information is true and accurate to the best of my knowledge:

Signature of Patient/Responsible Party_____
Date:_____

Clawson Physical Therapy

INSURANCE RELEASE

Name _____ Birth date _____

Social Security # _____-_____-_____Driver's License # _____

Insurance Company _____Member ID# _____

Secondary Insurance _____Member ID# _____

Doctor's Name and Phone # _____

With regards to medical care and services provided, it is agreed that David T. Clawson, MPT and Clawson Physical Therapy, it's Physical Therapists and Physical Therapy Assistants provide medical care and services to the patient such as: physical therapy and any other services deemed necessary and rendered to the patient by David T. Clawson, MPT, Clawson Physical Therapy, staff, physical therapists, physical therapy assistants, according to the best of their skill and knowledge.

David T. Clawson, MPT and Clawson Physical Therapy will obtain the patient's consent and his/her written authorization to release information, other than basic information, concerning the patient, except in those circumstances when David T. Clawson, MPT and Clawson Physical Therapy is permitted or required by law to release information.

The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, David T. Clawson, MPT and Clawson Physical Therapy may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of David T. Clawson, MPT and Clawson Physical Therapy's charges, including but not limited to insurance companies, health care service plans, or workers' compensation carriers.

FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she herby individually obligates himself/herself to pay for services, including any balances remaining after all benefits have been paid. Should the account be referred to an attorney or collection, the undersigned will pay actual attorney's fees and collection expenses.

MEDICAL ASSIGNMENT: I certify that the information given by me in applying for payment under Title XVIII of the Social Security act is correct. I request that payment of authorized benefits be made in my behalf.

ASSIGNMENT OF INSURANCE BENEFITS: The undersigned authorizes, whether he/she signs as agent or as patient direct payment to David T. Clawson, MPT and Clawson Physical Therapy of any insurance benefits otherwise payable to or on behalf of the undersigned for all services. It is understood by the undersigned that he/she is financially responsible for charges not covered by this agreement.

I understand that I have the right to a copy of this agreement and waive same unless requested at the time of signing.

The undersigned certifies that he/she has read the foregoing and is the patient, the patient's legal representative, or is fully authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____ **Date**_____

Patient / Guardian / Conservator