ALEXANDRIA
REHABILITATION
YOUR UPPER EXTREMITY SPECIALIST

HAND/OCCUPATIONAL THERAPY

Upon referral from a physician, Occupational Therapy services are provided in this clinic by a licensed Occupational (Hand) Therapist. These services are billed separately from Physician's services, with charges that are specific to Occupational Therapy. Occupational Therapists are required to conduct their own independent evaluation and establish a plan of care in order to bill for their services.

Billing Statements: You will receive charges on our bill for an Occupational Therapy evaluation plus all therapy treatment you have received. There may be an additional charge for specific supplies provided for use at home. Not all of these supplies are covered by insurance.

Co-pays: Some insurance plans require a separate co-pay and/or deductible for Occupational (Hand) Therapy. If you have a co-pay for your doctor's visit, it is possible that you will have a co-pay for Therapy services. Any co-pays should be paid on the same day that you receive therapy services.

Benefits and Prior Authorization: Some insurance plans have limitations on the number of therapy visits they will allow per calendar year. It is your responsibility to find out the number allowed in your plan. For instance, most HealthPartners and Tricare plans only allow 20 therapy visits per calendar year (additional visits would require an authorization). Ucare only allows one visit (additional visits would require an authorization). If you have had any therapy services this year (even if not for your current problem), it is imperative that you inform us. If your insurance denies payment for lack of prior authorization, the cost of treatment will become your responsibility.

Prior to Your Next Therapy Appointment: If you are scheduled for follow up therapy services after your initial evaluation, it is your responsibility to check with your insurance company on therapy coverage, limitations and co-pays. If you have had therapy services performed with another therapy group within this calendar year, it may affect your remaining therapy benefits. Please indicate below if you have received any therapy services this year for ANY problem at another facility.

☐ **YES** **Name of Facility:** _____ **# of visits:** _____
☐ **NO**

Treatment Initiated Without a Physician Referral: Occupational Therapists in Minnesota are permitted to initiate therapy without a physician referral. However, most insurance policies require a physician referral. If you choose to have treatment without a physician referral, Alexandria Rehabilitation will bill your insurance company. It is possible that your health insurance will deny payment for the therapy. In this event, the cost of treatment will become your responsibility.

I have read and understand the above statement. I understand that I will be responsible for any and all charges regarding Occupational Therapy that are not covered by my health insurance.

Patient Name (Please Print): _____

Signature: _____ **Date:** _____

Patients covered by Medicare: Please see reverse side.

THANK YOU FOR CHOOSING ALEXANDRIA REHABILITATION!
PHONE: 320.335.2515 | FAX: 320.335.2717
www.alexrehab.com

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For Our Medicare Patients:

Medicare has an annual payment limit (called a cap) of **$1940.00** on Physical Therapy/Speech Therapy and **$1940.00** on Occupational Therapy services. All therapy services billed to Medicare require the patient to meet specific medical necessity criteria including a loss of function and the ability to make improvement. This is determined by the therapist and is based upon the criteria established by Medicare. If after reaching maximum improvement you choose to continue treatment beyond the cap without meeting medical necessity, you will be responsible for all therapy charges above the $1940.

These limits apply to all Physical/Speech and Occupational Therapy services provided including services performed as an outpatient at the hospital. Some therapy services provided in the home are excluded.

Due to the potential financial impact to our patients, it is very important that you inform your therapist of all therapy services received during the current year regardless of the location (home, hospital, clinic, etc.).

We are committed to providing the best service for you and will do our best to make sure you do not exceed the cap; or if you do reach the cap that you are meeting the necessary coverage policies.

Please **initial** below if you have received or are currently receiving the services listed during the current year.

_____ Outpatient Physical/Speech Therapy

_____ Outpatient Occupational Therapy

_____ Home Health Care ☐ Currently ☐ This Year

Please sign below verifying that you have been informed of the outpatient therapy limitations and that any expenses incurred for Occupational Therapy as described above may be your financial responsibility.

Patient Name: _____
Print

Patient Signature: _____ **Date:** _____