Payment Responsibility
Goffstown Physical Therapy
Medicare Insurance

Medicare's Policy for Physical Therapy

Your insurance requires that we, as your physical therapy provider, keep in close contact with your doctor. Your therapist will send a progress note to your doctor to get recertification that is needed. Unless you have seen your doctor, whether it be your Primary Care Physician or your Specialist, within the last 30 days, Medicare will not cover your physical therapy visit, in which case you would be responsible for payment.

Medicare Cap for 2020

As of January 2020, Medicare has established a financial cap on Physical Therapy (PT) and Speech and Language Pathology (SLP) combined. This cap allows $2080.00 for both benefits combined per calendar year. If you have received PT or SLP elsewhere this year, it is important that we be informed, as it would lessen your allowable benefit by the amount used up to this point. We will be diligent in informing you where your benefit stands throughout the course of your treatment here.

Medicare Deductible for 2020

As of January 2020, Medicare has established a $198.00 deductible for the year. After your deductible has been met, you will be responsible for 20% of the Medicare- approved amount for the service provided. If you have a secondary insurance, the Medicare co-insurance should be covered.

****

As a courtesy to our patients, we will bill Medicare and secondary insurances. To do so we need to have your updated Insurance information and any paper work (i.e., referrals, prescriptions, or managed care certification) required by your insurance.

- I understand that I am responsible for any payment that may be due at the time of each visit. This may include, but not limited to, co-payments, coinsurance, deductibles, or non-covered services. Additionally, I am responsible for knowing my insurance benefits and limitations.
- I give permission to Goffstown Physical Therapy to release information to my physician, insurance company, and or attorney.
- I authorize release of payment to Goffstown Physical Therapy for professional services rendered.

_____ _____

Signature Date

_____

Member ID Number