THERAPY IN YOUR HOME – OT, PT, ST
OUTPATIENT OCCUPATIONAL, PHYSICAL, AND SPEECH THERAPY
147 Vista Del Monte, Los Gatos, CA 95030 • Phone (408) 358-0201 • Fax (877) 334-0714
www.TherapyInYourHome.net Office@TherapyInYourHome.net

WELCOME!

Thank you for choosing Therapy In Your Home, OT, PT, ST, an OUTPATIENT therapy service provided in your home. We help match therapists with clients who need therapy in their home or community.

When working with Therapy In Your Home OT, PT, ST, the client is matched with a therapist based on the diagnosis, location, therapist specialty, and client's payer choice. To get therapy started, the following intake documentation will need to be completed in order to confirm your contact information and to whom services will be billed.

The attached documents that should be returned to us are:

1) Medicare Payment Document (2 pages)
2) Your Story! Document

- **Please note: We are not a provider of Home Health Services. Medicare Home Health services are billed under Medicare Part A. We provide Outpatient Therapy which is billed under Medicare Part B. Thus, if you are receiving Home Health services, even periodically, you will need to pay privately for therapy provided by us if it is provided at the same time. To avoid this, please inform us if you are using any Home Health services.**

Tips to get the most out of your therapy services

- These are your visits. Be sure to share your goals and/or concerns with your therapist.
- The therapist will be your direct contact for scheduling and billing. Be sure to get their contact information before your first visit.
- Please complete these intake documents as much as possible; otherwise missing information may delay the start of services
- Missed Visits: Check with your therapist regarding their policy on cancellations. Be sure to follow their cancellation policy. Additional costs due to non- cancellation cannot be billed to insurance and will be billed to you.
- Communication helps the results of therapy.
  - Tell us or your therapist before you have an MD appointment so we can send a report
  - Involve us with your friends and family so we create a team of support. We will not share information unless OK'd by you. We follow strict confidentiality / HIPPA rules (see our website) Please help us help you by sharing names and contact information for people and agencies who might be of help to your treatment:
    ____
    ____
    ____

- You may send pictures of your insurance cards instead of completing some of the lines in the payment document.
- Please send completed and signed documents to the address, fax or email noted in our letterhead. Please write clearly and fill in information completely, otherwise it will delay start of services.

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MEDICARE PAYMENT INFORMATION Page 1 of 2

Date: _____________
Patient Name:____ **DOB**: ______________________
Treatment address: ____
Billing address:____
Telephone # ____ **Alt #**___________________________________
Email address: ____________________________________ **Place of work**: _____________________________
Emergency contact person:
Name:____ Phone: ____________________________
Address:____ email: _________________________________

Referring MD/Specialty: _____________________________________ **Phone:** _________________________
Fax #_______________________ **Address of MD:** ____
Other MD/Specialty: ____ **Phone:** _________________________
Fax #_______________________ **Address of MD:** ____

Name of Insured: ____ **Relationship**:________________
Medicare # ______________________ **Name exactly as on card:** ____________________________________
Medicare Type: (choose one) HMO/Advantage _____ Straight Medicare_____
Is there an insurance that is primary to Medicare? Y N // Are you a Veteran? Y N
Is your condition related to Employment, Auto accident, Other accident? Y N
Do you have Medi-gap, Group Health Plan Y N (# employees____), is it for disability Y N
ESRD or black lung? Y N // Are you (circle): Single Married Other
(circle) Employed // Full time student // Part time student // Do you have Medi-Cal? Y N

Secondary Insurance to Medicare: _______________________________ **Phone #** _____________________
Name exactly as on card:____
ID #:__________________________ Grp#________________________
Insurance Billing address: ____

BILLING MEDICARE:
Your therapy is **OUT PATIENT** which we provide IN THE HOME. These are NOT Home Health Services.
If you receive ANY home health during your visits you will need to pay for your therapy visits yourself. Medicare B will not pay. Tell us immediately if you receive a visit from a Home Health Agency.
- If you qualify for Home Health, under Medicare part A, use those services first.
- There is a limit or threshold on the amount of Outpatient services Medicare will cover.
- Medicare will pay for 80% of allowed amount and bill your secondary IF they know who the secondary is. Otherwise you are responsible for the 20% even if you have Medi-Cal unless you are a Qualified Medicare Beneficiary (QMB) under Medicare .

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MEDICARE PAYMENT PAGE 2 of 2

Other Information We Need: (Please submit as directed above.)

1. Prior therapy this year: # Out-Patient visits: PT_____ OT______ ST______
2. Dates of Any Home Health Agency care: ____________________________
   Name of Company: ____
3. **PLEASE ASK YOUR DOCTOR TO FAX a prescription for this therapy to 1-877-334-0714 and should include ICD-10 diagnosis codes**
4. Medication list. Please be sure to update us on all changes.
5. ABN (Advance Beneficiary Notice) (Needed when paying privately and not using your Medicare)

I agree to the Rights and Responsibilities, HIPPA document on website, and to pay for services not covered by Medicare:

Patient Name: ____

Signed: ____

Print Name: ____Relationship:__________________

DATE: _________________

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YOUR STORY!

Who completed this information? ________________________________

Please provide us with information that will help us know you better.
We appreciate this information as it helps us be better therapists for you. You can provide as much or as little information as you like. Remember: this form is used for all ages and abilities, so the questions may or may not be relevant. If you have already told us on the phone, you don't need to repeat it here.

What have you done in the past that was important to you?

How do you like to spend your time?

Who are the people and routines that help you the most through hard times?

Who are you worried about within your support network and why?

What do you know about your condition? What has your doctor told you?

How will you know if we are helping you?

What are your fears and what are your goals?

What do you see yourself doing to assist in getting those goals met?

Here's to feeling confident and satisfied!
Julie Groves and your Therapists

2/20/20