New Hampshire Hand Therapy Center, Inc.
80 Palomino Lane, Suite 401
Bedford , NH 03110
Phone 603-669-7716 Fax 603-669-0103

MEDICARE FEE AGREEMENT, BILLING POLICY & CONSENT TO TREATMENT

Patient's Name: ______________________________ Date of Birth: ____________________

1. **I have consented to treatment at New Hampshire Hand Therapy Center, Inc. ("NHHTC"). I hereby authorize direct payment to NHHTC of any Medicare benefits to which I am entitled for this treatment. I understand that Medicare will cover 80% of the approved charges for therapy services and that NHHTC is required to bill me for the deductible and remaining 20% co-payment for such services. NHHTC agrees to submit my claims to my secondary carrier also, if I have one. The 2008 Medicare cap is $1810.00. Many diagnoses are exempt and our office will review this with you directly.**

2. **I understand that Medicare requires that a physician refers me for therapy with a written prescription initially. The therapist will recertify with a report to the physician every 30 days. If I miss 30 consecutive days or more, I understand it is my responsibility to see the physician for a new prescription.**

3. **I understand that Medicare will <u>not</u> pay for certain supplies or treatments that NHHTC may determine are necessary for my treatment and home program, such as home exercise equipment, hot packs, cold packs and some electrical stimulation treatments. NHHTC will inform me, to the best of its knowledge, which supplies or treatments are not covered by Medicare, if and when such supplies or treatments are recommended. I must pay for those supplies or treatments on the day I receive them unless alternate arrangements are approved by the NHHTC office staff.**

4. **I authorize the release of any information (including medical records) requested by Medicare or its agents to facilitate payment for the services rendered by NHHTC. I authorize such information to be transmitted by mail, telephone, facsimile, or other electronic means. I understand that I am ultimately responsible for payment of any medical bills for services provided by NHHTC that are not otherwise reimbursed by Medicare.**

(SEE REVERSE SIDE OF FORM)

I have read this form carefully and had an opportunity to ask any questions about it, and those questions have been answered.

____
Print Name

______________________________ ______________________
Signature/Date Witness

COMPLETE THE FOLLOWING SECTION ONLY IF THE PATIENT LACKS THE CAPACITY TO SIGN THIS AGREEMENT

______________________________ ______________________
Print Name Witness

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Signature of Parent, Agent Under a Durable Power of Attorney for Healthcare, Guardian, or other Appropriate Consenting Party

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Relationship to Patient/Date

Revised 2/5/08