Hulst Jepsen Physical Therapy

Medicare Authorization Form

Patient's Name: _____Patient's Medicare #:_____

I request that payment of authorized Medicare benefits be made on my behalf to **Hulst Jepsen Physical Therapy, Inc** for any services furnished me by the therapists of HJPT. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claims. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, **Hulst Jepsen Physical Therapy, Inc** agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

I agree to the terms presented above and hereby request and authorize **Hulst Jepsen Physical Therapy, Inc.** to treat me.

Patient's Signature:_____Date:_____

Please answer Yes or No to the following questions:

1. Is this injury a result of an automobile or work related accident?

   Yes ☐ **No** ☐

2. Are you or your spouse currently employed?

   Yes ☐ **No** ☐

3. Have you received any type of home health care within the past 6 months?

   Yes ☐ **No** ☐ If yes, please indicate which agency_____

4. Do you have a secondary insurance policy?

   Yes ☐ **No** ☐