



MEDICARE PATIENTS

Height:_____ Weight:_____

Home-Health Services

Are you currently receiving any home services from any healthcare provider? ☐ Yes ☐ No

*If yes, please describe: _____

If you have recently been discharged from any Home-Health services, please provide our office with your discharge note or provide the following information so we may contact them.

Name of Company: _____ Telephone Number: _____

Outpatient Services

Are you currently receiving Physical or Speech Therapy services? ☐ Yes ☐ No

Have you received Physical or Speech Therapy services since January 1st? ☐ Yes ☐ No

*If yes, are you aware of the amount used since January 1st? _____

Medicare as a Secondary Insurance

If Medicare is your secondary insurance, please tell us why by selecting the appropriate reason:

- ☐ Working Aged 65 or Older
- ☐ End Stage Renal Disease
- ☐ No-Fault Situations
- ☐ Workers Compensation
- ☐ Black Lung Benefits
- ☐ Veterans Administration
- ☐ Disability under age 65 and under Spouse's plan
- ☐ Liability Situations