

**Medfield**  
orthopedic  
& sports  
**Therapy**

**FOR MEDICARE PATIENTS ONLY**

I authorize **Medfield Orthopedic & Sports Physical Therapy, LLC** to release to the **Social Security Administration and Health Care Financing Administration** or its intermediaries or carrier, any information needed for this or any related medical claim. I permit a copy of this authorization to be used in place of the original and request payment of the medical insurance benefits to **Medfield Orthopedic & Sports Physical Therapy, LLC**, who, as a contracted provider, accepts assignment of benefits..

**Physical therapy in an out patient setting is covered under Medicare Part B. They pay for 80% of their allowed charge after your yearly deductible has been met. The deductible and the remaining 20% is billed to your secondary insurance. Some secondary insurance plans cover all of this deductible and 20% and some don't cover any of it. If your secondary plan doesn't cover the deductible and/or the 20%, you will be financially responsible for this. The deductible changes every year, currently it is about \$150 and 20% of each visit is approximately \$15-25. Since secondary plans vary, you must call member services of your secondary insurance to find out what your plan covers and what your financial responsibility will be. If this presents a financial hardship, please speak to one of the owners to arrange a payment plan.**

\_\_\_\_\_ According to benefit information we have obtained, your secondary plan does not cover the deductible and the 20% of the allowed charges. Therefore, you will be financially responsible for this. We encourage you to make a small payment at each visit to avoid receiving a lump sum bill. Kindly inform our front office staff if you wish to do this.

**Patient Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**You may request a copy of this form at any time**

