Home Health Consent

Disclaimer for Medicare Patients

Home Health:

Have you had any Health Care Services provided in your home in the last 60 days (i.e.; Therapy, Wound care, Diabetic care, etc.)? ☐ Yes ☐ No If yes, Date of last service_____

Name of Agency: _____Telephone Number of Agency_____

If you have received, or are receiving any Home Health Services: You must be discharged from any home healthcare services prior to initiating outpatient physical therapy.

☐ I authorize my home healthcare agency to release to Progressive Therapeutics a copy of my discharge summary.

☐ I further more consent that I do not have any home health care (Nurse, Nurse Aide, Caregiver, Physical therapy, Occupational Therapy) within the last 60 days or at present time. And in case home health care is provided to me and I still would like to receive services from Progressive Therapeutics, I will be responsible for all payments for services rendered by Progressive therapeutics to me.

Other Services:

Have you received Physical Therapy or Speech Therapy elsewhere this year ? ☐ Yes ☐ No

If yes, where did you receive therapy? _____

Other Insurance:

Is this injury covered by: ☐ Auto Insurance ☐ Employer' Insurance ☐ Legal Case

Do you have a Secondary Insurance? ☐ Yes ☐ No If yes, please present at 1st visit.

X_____

Authorized Signature Date