MEDICARE QUESTIONAIRE

This questionnaire is for Medicare patients only. It will help us determine if you qualify for coverage under the Medicare program. It is the responsibility of your evaluating therapist to determine your coverage. If it is determined that services are non-covered, you will be asked to pay for these services at the time they are rendered. Please complete the following questions completely and concisely. Thank you.

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1. Do you have a physician signed prescription? Yes No
2. Have you received Home Health Care within the last 6 months? Yes No
3. Briefly describe your significant medical history (relative to this injury/illness).
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4. What is the date of onset? ___/___/___ If this is a chronic condition, indicate the most recent date that you experienced a "flare up". (Medicare does require an exact date).
5. How did the "flare up" occur or what were you doing when you noticed the increase in pain?
   ____
6. What are your current medical findings (i.e.: x-ray results, MRI findings, etc.):
   ____
   ____
7. Are you aware of your diagnosis and prognosis? Please describe:
   ____
8. Summarize any previous rehabilitation treatment you have received for this injury, and the time frame in which you were treated. (i.e.: physical, occupational, massage therapy; chiropractic treatment, etc.)
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9. Describe how this injury/illness interferes with your daily living activities or your ability to carry out and perform tasks required in your daily life. (i.e.: unable to lift arms to comb your hair, unable to stand in the shower without assistance, unable to bend down to socks and shoes, etc.) ______________________________
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Patient Signature Date