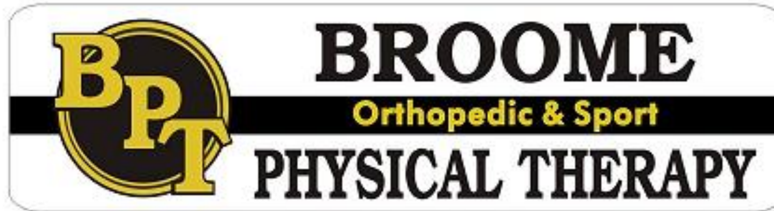


BROOME ORTHO & SPORTS PHYSICAL THERAPY
800 VALLEY PLAZA, SUITE 9
JOHNSON CITY,NY 13790-3305

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB)

The Balanced Budget Act 1997,P.L. 105-33, Section 4541 set annual caps for Part B Medicare Patients. These limits change annually. The Deficit Reduction Act of 2005 (signed Feb.8,2006) directed that a process for exceptions to therapy caps for medically necessary services be implemented. Subsequently, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15,2008 and Section 141 extended the effective date of the exceptions process to the therapy caps to December 31,2017. The exceptions process will continue unchanged for the time frame directed by Congress.

For Physical Therapy/Speech Services, the limit is **$1980.00** for the calendar year **2017.** The limit is based on incurred expenses and includes applicable deductible and coinsurance.

I HAVE READ THIS NOTICE AND UNDERSTAND THAT THE LIMIT FOR PHYSICAL THERAPY/SPEECH SERVICES FOR THE CALENDAR YEAR **2017** IS : $**1980.00.**

____

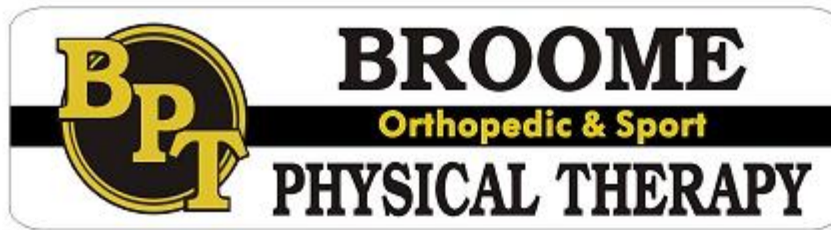
PATIENT NAME

____

PATIENT SIGNATURE

____

DATE OF SIGNATURE



Medicare Secondary Payer Questionnaire

Patient Name: _________________________ Date of Birth:______________________

Part I

1. Are you receiving Black Lung Benefits? ________________
2. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility? _________________
3. Was the illness/injury due to a work-related accident/condition? ___________________
4. Was the illness/injury due to an automobile accident? ___________________

Part II

1. Was the illness/injury due to a non-work related accident? ____________________
   Date of Accident:_____________________
2. What type of accident caused the illness/injury? _____________________________

   Name, address and claim number for No-Fault insurer:

   ____

   Name, address and claim number for Liability insurer:

   ____

   Name, address, claim number and employer for Worker's Comp insurer:

   ____

Part III

1. Are you entitled to Medicare based on age or disability? _________________________
2. Are you currently employed? __________. If currently employed name and address of your employer: ____
3. Is your spouse currently employed? __________. If your spouse is currently employed employer name and address ____
4. Do you have group health plan coverage based on your own current employment or based on employment of your spouse? ___________. If yes please list name of Group health provider

DIZZINESS HANDICAP INVENTORY – Initial Visit

Name: ____**Date:**__________________________

SECTION I

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

SECTION II - Part I

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please indicate answer by circling "yes or "no" or "sometimes" for each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.

P1.	Does looking up increase your problem?	Yes[1]	No[2]	Sometimes[3]
E2.	Because of your problem, do you feel frustrated?	Yes[1]	No[2]	Sometimes[3]
F3.	Because of your problem, do you restrict your travel for business or recreation?	Yes[1]	No[2]	Sometimes[3]
P4.	Does walking down the aisle of a supermarket increase your problem?	Yes[1]	No[2]	Sometimes[3]
F5.	Because of your problem, do you have difficulty getting into or out of bed?	Yes[1]	No[2]	Sometimes[3]
F6.	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties?	Yes[1]	No[2]	Sometimes[3]
F7.	Because of your problem, do you have difficulty reading?	Yes[1]	No[2]	Sometimes[3]
P8.	Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem?	Yes[1]	No[2]	Sometimes[3]
E9.	Because of your problem, are you afraid to leave your home without having accompany you?	Yes[1]	No[2]	Sometimes[3] someone
E10.	Because of your problem, have you been embarrassed in front of others?	Yes[1]	No[2]	Sometimes[3]
P11.	Do quick movements of your head increase your problem?	Yes[1]	No[2]	Sometimes[3]
F12.	Because of your problem, do you avoid heights?	Yes[1]	No[2]	Sometimes[3]
P13.	Does turning over in bed increase your problem?	Yes[1]	No[2]	Sometimes[3]
F14.	Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes[1]	No[2]	Sometimes[3]
E15.	Because of your problem, are you afraid people might think you are intoxicated?	Yes[1]	No[2]	Sometimes[3]
F16.	Because of your problem, is it difficult for you to go for a walk by yourself?	Yes[1]	No[2]	Sometimes[3]
P17.	Does walking down a sidewalk increase your problem?	Yes[1]	No[2]	Sometimes[3]

F19. Because of your problem, is it difficult for you walk around the house in the dark? Yes[1] No[2] Sometimes[3]

E18. Because of your problem, is it difficult for you to concentrate? Yes[1] No[2] Sometimes[3]

E22. Has your problem placed stress on your relationships with members of your family or friends? Yes[1] No[2] Sometimes[3]

E23. Because of your problem, are you depressed? Yes[1] No[2] Sometimes[3]

F24. Does your problem interfere with your job or household responsibilities? Yes[1] No[2] Sometimes[3]

P25. Does bending over increase your problem? Yes[1] No[2] Sometimes[3]

E20. Because of your problem, are you afraid to stay home alone? Yes[1] No[2] Sometimes[3]

E21. Because of your problem, do you feel handicapped? Yes[1] No[2] Sometimes[3] **SECTION II - Part II**

Instructions: Put a check in the box that best describes you**:**

- ☐ **Negligible symptoms (0)**
- ☐ **Bothersome symptoms (1)**
- ☐ **Performs usual work duties but symptoms interfere with outside activities (2)**
- ☐ **Symptoms disrupt performance of both usual work duties and outside activities (3)**
- ☐ **Currently on medical leave or had to change jobs because of symptoms (4)**
- ☐ **Unable to work for over one year or established permanent disability with compensation payment**

Falls Efficacy Scale

Take a bath or shower

1: Very Confident 2 3 4 5 6 7 8 9 10: Not At All Confident

Reach into cabinets or closets

1: Very Confident 2 3 4 5 6 7 8 9 10: Not At All Confident

Walk around the house

1: Very Confident 2 3 4 5 6 7 8 9 10: Not At All Confident

Prepare meals not requiring carrying heavy or hot objects

1: Very Confident 2 3 4 5 6 7 8 9 10: Not At All Confident

Get in and out of bed

1: Very Confident 2 3 4 5 6 7 8 9 10: Not At All Confident

Getting dressed and undressed

1: Very Confident 2 3 4 5 6 7 8 9 10: Not At All Confident

Personal grooming (i.e. washing you face)

1: Very Confident 2 3 4 5 6 7 8 9 10: Not At All Confident

Getting on and off the toilet

1: Very Confident 2 3 4 5 6 7 8 9 10: Not At All Confident