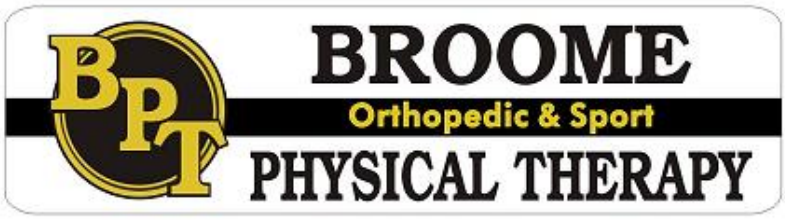

BROOME ORTHO & SPORTS PHYSICAL THERAPY
800 VALLEY PLAZA, SUITE 9
JOHNSON CITY,NY 13790-3305

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

BROOME Orthopedic & Sport PHYSICAL THERAPY

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._____

PATIENT NAME: _____ ID#: _____ DATE: _____

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

LEFS – INITIAL VISIT

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

	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1. Any of your usual work, housework or school activities	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3. Getting into or out of the bath	0	1	2	3	4
4. Walking between rooms	0	1	2	3	4
5. Putting on your shoes or socks	0	1	2	3	4
6. Squatting	0	1	2	3	4
7. Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
8. Performing light activities around your home	0	1	2	3	4
9. Performing heavy activities around your home	0	1	2	3	4
10. Getting into or out of a car	0	1	2	3	4
11. Walking 2 blocks	0	1	2	3	4
12. Walking a mile	0	1	2	3	4
13. Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
14. Standing for 1 hour	0	1	2	3	4
15. Sitting for 1 hour	0	1	2	3	4
16. Running on even ground	0	1	2	3	4
17. Running on uneven ground	0	1	2	3	4
18. Making sharp turns while running fast	0	1	2	3	4
19. Hopping	0	1	2	3	4
20. Rolling over in bed	0	1	2	3	4