NOTICE TO MEDICARE PATIENTS REGARDING HOME HEALTH CARE

Patient Name:_____ Medical Record Number:_____

Are you currently receiving home health services*? (circle one) YES NO

*Home health services include a nurse, therapist, aide or social worker provided by a home health agency coming to your home for any reason that is paid for by Medicare. Examples include rehabilitation therapy, blood tests, wound care, nursing visits, and physical care assistance.

If you circled "**YES**":	Medicare will **not** cover your therapy services at the Shirley Ryan AbilityLab. If you receive therapy services at Shirley Ryan AbilityLab, you are responsible for payment in full.
If you circled "**NO**":	You are responsible for informing the Shirley Ryan AbilityLab clinic manager if you need/receive home health services at anytime during your treatment at Shirley Ryan AbilityLab. If you receive therapy services at Shirley Ryan AbilityLab while receiving home health services, Medicare will **not** cover your Shirley Ryan AbilityLab therapy services and you will be responsible for payment in full.

I have read the above statements or have had them read and explained to me in a language which I understand. I fully agree to each of the statements in this Notice and sign below as my free and voluntary act.

_____ _____
Patient or patient's decision maker signature Date

_____ _____
Hospital Representative Witness Date