FYZICAL® Therapy & Balance Centers

ADVANCE Physical Therapy

ATTENTION: MEDICARE PATIENTS

If you have Medicare as your primary health insurance, please complete this form.

1. Have you received ANY Home Health Care during this calendar year or within the past 6 months? _____ **If yes, please continue.**

2. What is the reason you were receiving Home Health Care (medication, therapy, shots, care, etc)? _____

   _____

3. What company provided your Home Health Care?

   _____

4. When were you discharged from Home Health Care?_____

   MEDICARE REQUIREMENT

5. Have you ever been diagnosed with depression and/or bi Polar disorder?

   YES OR NO

I attest that the above statement(s) are true and correct.

_____ _____

Signature Date