BodyBalance physical therapy

Move more, Live more!

COMMERCIAL INSURANCE

***All* Patients or Patients' Legal Representative, please complete all Sections**

(1) Patient: (Full Legal Name or as on Insurance Card)

Name: _____
Last First Initial Sr. Jr.

Address:_____
Street Apt# City State Zip Code

Phone: (_____) _____-_____ (_____) _____-_____ (_____) _____-_____ (_____) _____-_____
Home Mobile Work Emergency

Email: _____

Sex: M F **Birthdate:** _____/_____/_____ **S.S #** _____/_____/_____

(2) Condition to be treated in Physical Therapy:_____

Date Condition Began?			Date:____/____/____
Is it Related to an Auto Accident?	No	Yes	Date of Accident ____/____/____
Is it Non-Work Related Accident?	No	Yes	Date of Accident ____/____/____
Did this Condition Result in Surgery?	No	Yes	If Yes Date of Surgery ____/____/____
Have You Had PT for this Condition?	No	Yes	If Yes Where?_____
Have You Had Chiropractic Services for this Condition?	No	Yes	If Yes Where?_____

(3) Patients Doctor

Referring Doctor: _____ **Primary Doctor**:_____

(4) If Filing Insurance : Check A or B

A. ____ **Patient is the insured** (Do not need to complete the rest of #4 or any of #5)

B. ____ **Insured is** ___**Spouse** ____**Parent** (Complete all of #4 and all of #5)

_____
Name: Last First Initial Sr./Jr.

_____
Address: Street Apt.# City State Zip Code

Phone: (___) ____-_____ (___) ____-_____ (___) ____-_____ (___) ____-____
Home Mobile Work Emergency

All Patients or Patients' Legal Representative Please Sign Section 9 on Page 3

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(5) Insured Person:

Complete if not the patient

Date of Birth: ____/____/____ **S.S. # _____/_____/_____**

Insured's Sex: M F **___ Employed ___ Unemployed ___ Retired**

(6) Employer Information (Please complete if the insured person's employer is the source of benefits)

Employer Name: _____Employer Phone # ( ) _____- _____

Address: _____ _____
Street City State Zip Code

Name of Employer Contact: _____ Contact's Phone # ( ) _____- _____

(7) Payor Information:

Primary Insurance Company:

Ins. Co. Name: _____Insured's Name: _____ Ins. Ph #_____

Patient ID #: _____Group. # _____ Policy/Plan #:

Secondary Insurance Company: (If YES, please complete) **Insured is: _____Patient _____Spouse _____Parent**

Ins. Co. Name: _____Insured's Name: _____ Ins. Ph#_____

Patient ID #: _____Group. # _____Policy/Plan #: _____

Claims Mailing Address:_____
Street City State Zip Code

Employer Name: _____ Employer Phone # ( ) _____- _____

Address: _____ _____
Street City State Zip Code

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(8) Payment Authorization: ***(Initials required for all 3 statements)***

_____ **Assignment of Insurance Benefits**

Initials **I authorize that the payment of my insurance benefits be made directly to Body Balance Physical Therapy for any services that are reimbursable by Medicare or any other Insurance company, if I have one.**

_____ **Guarantee of Payment**

Initials **I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by the billing statement due date.**

_____ **Certification of Information**

Initials **I certify that the information I have provided Body Balance Physical Therapy for payment including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.**

(9) Signature/ Date:

_____ _____

Patient or Legal Representative's Signature **Today's Date**