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COMMERCIAL INSURANCE

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

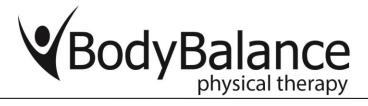
(1) Patient: (Full Legal Name or as on Insurance Card)					
Name:					
Last First		Initial Sr. Jr.			
Address: Street Apt#	City	State	Zip Code		
	·				
Phone: () () . Home Mobile		()	_ () Emergency		
Email:					
Sex: M F Birthdate:	//	S.S #	//		
(2) Condition to be treated in Physic	al Therapy:				
Date 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:	Prin	nary Doctor:			
(4) If Filing Insurance : <u>Check</u> A or B					
A Patient is the insured (Do not need to	o complete the re	est of #4 or any of #5)			
B Insured isSpouseParent(Complete all of #	[±] 4 and all of #5)			
Name: Last First	Initial	Sr./Jr.			
	0:4				
Address: Street Apt.#	City	State Zip Code			
Phone: () Home Mobile	() Work	() Emergency			



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(5) Insured Person:					
Complete if not the patient					
Date of Birth:/		S.S. #//			
Insured's Se	x: 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:PatientSpouseParent					
Ins. Co. Name:	Insured's Name: _	Ins. Ph#			
Patient ID #:	Group. #Po	licy/Plan #:			
Claims Mailing Address:					
	Street	City State Zip Code Employer Phone # ()			
Address: Street	City	State Zip Code			
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(8) Payn	nent Authorization: (Initials required for all 3 statemen	ts)		
	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 <u>or</u> 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) Signa	ature/ Date:			
Patient c	r Legal Representative's Signature	Today's Date		