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Insurance Information -Active Fitness & Physical Therapy

It is a patient's responsibility to know their Insurance benefit for PT services, as a courtesy our billing department will confirm policy benefits for our records and may review them with you. Please ask if you have any questions or do not understand your insurance coverage.

Patient Name: _____ Date_____

Primary Insurance Physical Therapy Coverage? Yes No

Insurance Co. Name: _____ Phone#: ( ) _____ Insured's Name: _____

ID # _____Group# _____ Insured's SS#: _____ Insured's DOB: _____

Relation: _____Insured's Employer: _____ Employer's Address: _____

Deductible: _____ Amt. Met: _____ CoPay: _____

Visit Limit: _____ Auth Needed: _____ Auth Number: _____

Secondary Insurance Physical Therapy Coverage? Yes No

Insurance Co. Name: _____ Phone#: ( ) _____ Insured's Name: _____

ID # _____Group# _____ Insured's SS#: _____ Insured's DOB: _____

Relation: _____Insured's Employer: _____ Employer's Address: _____

Have you received Chiropractic or Physical Therapy treatment during your current insurance benefit period? Yes No When _____ Where _____

Authorization for Payment

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this physical therapy office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this physical therapy office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me to be credited to my account. **However, I clearly understand and agree that I am personally responsible for payment for all services rendered me.** I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. Collection fees and/or interest fees may apply on any unpaid account balance.

It is customary to pay your Co pay when services are rendered. If you are unable to make full payments at each appointment we will accept a reduced payment and bill the remaining balance at the end of your services. Payments may be made on your balance.
If you are retired, on disability or have limited income we have a sliding scale and may reduce or waive your deductible or copay. Please ask us for details.

By signing below, I acknowledge that I understand & agree to the insurance information that Active Rehab Services Inc DBP: Active Fitness & Physical Therapy has discussed with me today. I also agree to pay the deductible amount and any co-payments that are due at the time of my visit unless payment arrangements are made.

Signature_____ **Date**_____

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