[1]

WORKERS COMPENSATION

Insurance Information

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.
Please be sure your account balance with us is paid before you settle with Workers Compensation.
You are responsible for paying any account balance remaining at the time of settlement.

Patient Name: _____ Date_____

Date of injury/accident _____ Claim #: _____ State _____

Referring Doctor _____ In PPO? Yes No If No- Auth #_____

Claim Manager _____ Phone #: _____ Extension _____

Do you have an attorney for this claim? Yes No If yes, complete the following:

Attorney's Name: _____ Phone #: _____

Insured's Employer: _____ Employer's Address: _____

If your claim is not covered by Workers Compensation we may bill your private insurance. Please provide your health insurance below:

Primary Insurance Physical Therapy Coverage? Yes No

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

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

Relation: _____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: _____

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.

By signing below, I acknowledge that I understand & agree to the insurance information that Active Rehab Services DBA Active Fitness & PT has discussed with me today. I also agree to pay for any services provided to me that are not unpaid by insurance.

Signature_____ **Date**_____

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