BACK TO BALANCE
Physical Therapy

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Is this injury related to a Worker's Compensation Injury? Yes / No Motor Vehicle Accident? Yes / No
Do you have an Attorney for this Injury? Yes / No Attorney's Name: _____

Address: _____ Phone: (_____) _____-_____ Fax: (____)____-_____

Financial Policy

I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am responsible for all charges regardless of my existing medical coverage. I understand that I am responsible for all supplies, such as braces or exercise equipment, which I am provided during treatment if they are not covered by my insurance plan. I understand that I will pay for supplies upon receipt.

I hereby give authorization for payment of insurance benefits to be made directly to Back to Balance Physical Therapy for services rendered. In the event that my insurance company forwards payment directly to me, instead of Back to Balance Physical Therapy, I will immediately deliver said payment to Back to Balance Physical Therapy. I understand & agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due, upon demand. I understand and agree that if it becomes necessary for Back to Balance Physical Therapy to utilize an outside collection agency or to commence court action, for the collection of any outstanding charges, I will be responsible for the outstanding balance, and in addition attorney fees, court costs and other expenses of litigation.
I agree to release of medical or other information necessary to process my claim.

Signature of Person Responsible for Charges: _____ Date: _____
(Parent or Legal Guardian must sign if patient is under the age of 18)
Relationship to Patient if Patient is under 18 of age: ( ) Mother ( ) Father ( ) Legal Guardian

Release of Information

I understand that Back to Balance Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payments, understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that Back to Balance Physical Therapy will consider requests for restriction on a case-by-case basis but does not have to agree to requests for restrictions.
I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.
Please give the name(s) of the individual(s) who you will allow to receive any part(s) of your health record.

Authorized Individual: _____ Relationship: _____
Patient Name: _____DOB: _____

Signature: _____Date: _____