Body In Balance Physical Therapy

Name:	Date of Birth: / /
Address:	Sex: M_______ F_______
City / State / Zip:	Cell Phone:
Employer:	Home Phone:
Primary Care Physician:	Email Address:
Referring Dr.:	Emergency Contact Name:
	Emergency Contact Phone:

Please check the appropriate type of claim and complete the corresponding information box below.

Health Insurance ______________ Workers Comp ______________ Auto Accident ______________

PRIMARY HEALTH INSURANCE INFORMATION

Health Insurance:	**Subscriber:**
Address:	Address:
City / State / Zip:	City / State / Zip:
Group #:	Relation to subscriber:
Cert #:	Subscriber date of birth:
Phone:	Subscriber employer:

SECONDARY HEALTH INSURANCE INFORMATION

Health Insurance:	**Subscriber:**
Address:	Address:
City / State / Zip:	City / State / Zip:
Group #:	Relation to subscriber:
Cert #:	Subscriber Date of Birth:
Phone:	

WORKERS COMPENSATION OR AUTO ACCIDENT INFORMATION

Subscriber:	**Insurance Co.:**
Address:	Address:
City / State / Zip:	City / State / Zip:
Phone:	Phone:
Contact:	Contact:
Date of injury:	Claim #:

PAYMENT AND STOP-TREATMENT POLICY

IMPORTANT... ***We can bill your insurance as a courtesy. BUT you are responsible for payment of your bills. YOU are responsible to pay for services not paid by your insurance, including co-pays and co-insurance.***

WE MAY STOP TREATMENT... ***We may stop treatment if you are not making adequate progress. We may stop treatment if you miss two appointments.***

RELEASE OF INFORMATION AND AUTHORIZATION TO PAY

I authorize BIBPT to release any information necessary to process insurance claims, inform my physician, or insurance company.______ (Initial) I have been offered a copy of BIBPT notice of privacy practices and understand that BIBPT will protect my information from unauthorized release.______ (Initial) I understand the above payment & stop-treatment policies. ______ (Initial) *I authorize insurance payments to be made directly to BIBPT. I understand my insurance may not pay for all services and materials and accept responsibility to pay for that which is not paid by insurance.* ***______ (Initial)***

Patient Signature: ____ ***Date:*** ________________________