Integration Physical Therapy Insurance Information

Name:____ DOB: ____________ Patient #: _________

Name of Insurance Company:___________________________ ID/Member number:______________________

Group or Acct Number:_________________________________ Specialist Co-Pay Amount:________________

Insured's full name:____________________________________ Relationship to Insured:__________________

Insured's Employer:____

It is your responsibility to know coverage, available benefits and service maximums for any company you ask us to bill. We will attempt to bill your Worker's Compensation and/or Accident insurance company on your behalf, but you will ultimately be responsible for payment of your account. Please be aware that if your Worker's Comp. and/or Accident insurance denies payment, we will bill your private insurance. if both deny payment, you will be responsible for the full balance of your account.

Initials:___________________

A. **Notice of Privacy Practices:** The policies and procedures of Integration Physical Therapy are designed to comply with the Health Insurance Portability and Accountability Act of 1996. I agree that the Privacy Notice of Integration Physical Therapy has been made available to me. Initials:__________________

B. **Authorization to Treat:** I authorized and direct the medical practitioners of Integration Physical Therapy and his/her designee to provide therapeutic, medical and diagnostic services for me as they deem necessary and appropriate. In understand that I have the right to receive information, to request treatment and to seek a second opinion. Patients 18 years and younger must be accompanied by guardian.

Initials:__________________

C. **Assignment of Insurance Benefits:** I hereby assign all medical insurance benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to Integration Physical Therapy. I understand that I am financially responsible for co-payments, co-insurance, deductibles, and any other balance not paid by my insurance plans. Initials:__________________

D. **Medical Release:** I authorize Integration Physical Therapy to release information from my medical records to insurance companies, their agents and Health Care Financing Administration and its agents for the purpose of determining my medical benefits and for any benefits payable for related services.

I authorize Integration Physical Therapy to release and receive medical records between Primary Care and/or Referral physicians and other medical specialists, including personal trainers, for the purpose of coordinating treatment.
Initials:___________________

E. **Cancellation & Collection Agency Fees:** Because we offer one-on-one patient care and reserve time specifically for you, we have a 24 hour cancellation policy. If you arrive late, fail to show or cancel without proper notification for 2 or more appointments, we may consider not rescheduling you at our office.

In addition, if we are forced to utilize a collection agency to recover your debts owed to this office, we are authorized to pass the fees form the Collection Agency (30% surcharge) on to you and include them in the amount payable to our office. Initials:___________________

The undersigned patient or patient's guardian hereby acknowledges to have read understood and agreed to conditions set forth in the Notice of Privacy Practices, Authorization to Treat, Assignment of Insurance Benefits, Medical Release and if applicable, Medicare Patient's Information

Signature:____ Date:__________________
If not signed by the patient, please indicate relationship to the patient:_________________________