

PHYSICAL THERAPY BENEFITS and ELIGIBILITY

Patient: _____

Insurance Co. /Attorney _____ Contact _____

Policy Holder _____ Policy Holders Date of Birth _____

Policy Holders Social Security # _____ Claim# _____

Address _____ City _____

State _____ Zip _____ Phone _____ Fax _____ Effective Date _____

PPO/HMO _____ Deductible _____ Co-pay for visit _____

Ins. Pay % _____ Patient Pay % _____

Adjustment _____

Notes _____

- Medicare:** Will bill Medicare, and secondary insurance, if applicable.
- Insurance:** Will bill Insurance as listed above.
- Medicaid:** **A.** Patients 21years of age and older: Patient or Authorized Agent/Representative will pay for treatment at time of receiving treatment. **B.** Patients under age of 21 years old: Will bill Medicaid.
- Legal:** At the end of physical therapy, IPT will send to your attorney bills and a final lien with total amount due. IPT will expect payment at time of judgment, verdict, and/or settlement equal to the final lien amount. IPT will not bill your insurance and if you or your attorney requires bills sent to your insurance, all payments are expected at time of service and all unpaid balances are due at time of notification by you or your attorney.
- Auto:** Will send billing to auto insurance and a lien at the end of treatment with total amount due. Will send 3 monthly statements to insurance company. **If no payment has been received at that time, you will need to make arrangements for payment, or initiate a payment plan.**
- Cash:** Payment at time of service, or by payment plan.
- Work Comp:** Will bill company or workers compensation insurance for work related injuries.

I, the undersigned, understand and agree to the benefits as they have been explained.

Patient or Authorized Agent/Representative Signature: _____ **Date:** _____

MEDICARE PATIENTS ONLY

Name of Patient _____ Medicare# _____

Supplemental Insurer _____ Policy# _____

I request that payment of authorized Medicare benefits be made on my behalf to Industrial Physical Therapy, Inc. for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me, to release to the above named supplemental insurer any information needed to determine benefits payable for services from this provider.

Medicare Patient's Signature _____ **Date Signed** _____