**INSURANCE PAYMENT INFORMATION**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DOB:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Billing address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telephone** #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Phone # **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Insurance Billing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name exactly as on card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_ ID**#\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Grp#\_\_\_\_\_\_\_\_\_

**Relationship to patient: ­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Circle all that apply**: Is this plan primary to Medicare? Y N // Are you a Veteran? Y N//

 Is the condition related to Employment, Auto accident, or Other accident? Y N

**Name of secondary insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Phone # **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Insurance Billing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name exactly as on card\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ID **#\_\_\_\_\_\_\_\_\_\_\_\_** Grp #\_\_\_\_\_\_\_\_\_

**Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referring MD and specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 FAX # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address of physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary MD and specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 FAX #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address of physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prior Outpatient Visits this year:** PT\_\_\_\_\_; OT\_\_\_\_\_\_; ST\_\_\_\_\_

**Any Dates of Home Health Agency Care:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Company**: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Prescription:** Please ask your doctor to fax a RX for this therapy to 877-334-0714.

**Medication list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Complete the following information if you know it:**

 Deductible per year $\_\_\_\_\_\_\_\_; Copay per visit $\_\_\_\_\_\_;

 Reasonable and Necessary rate per visit: \_\_\_\_\_\_\_\_; Preauthorization needed? Y\_\_ N\_\_

 # Visits allowed per year \_\_\_\_\_\_\_\_; Can more visits be requested Y\_\_ N\_\_

 Procedure to request more\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 out of pocket $\_\_\_\_\_

**Please Note: 24-hour notice required for cancellations or else you will be charged privately for half the cost of a visit.** Visits are 1-hour long according to most insurances. **Additional time not paid by insurance will be a private charge to you.**

**Out of Network**: Monthly billing statements due on receipt. Insurance will pay you. We do not know

 what your insurance considers a reasonable and customary charge. It could be as low as $60. Ask

 them how much they reimburse for 4 units (1- hour) of CPT code 97530, or 2 units each of 97110 and

 97535 in zip code 95030. Determine if it is more cost effective for you to pay privately or for us to

 bill your insurance when we’re not in network. Consider your copay, deductible and the difference

 between your charge from us and their limit.

**In Network:** Monthly billing statements due on receipt which reflect payments from the insurance and

 late cancelations, time over one hour, deductible and copays.

***I agree to the Rights and Responsibilities, HIPPA document on website, and to pay for services:***

***Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**