COMMERCIAL INSURANCE
Patient & Payor Information Form

***All* Patients or Patients' Legal Representative, please complete all Sections**

The Center for Balance

(1) Patient: (Full Legal Name or as on Insurance Card)

____
Name: Last First Initial Sr. Jr.

____
Address: Street Apt# City State Zip Code

Phone: (_____) ______-________ (_____) ______-________ (_____) ______-________ (_____) ______-_________
Home Mobile Work Emergency

(2) Patient

Sex: M F **Birthdate: _____/_____/______**

S.S # ______/______/_______ **Legal Photo ID #** ______________________
(Driver's License, Passport, Other State/Federal Photo ID)

(3) Condition to be treated in Physical Therapy: ______________________________________

Date Condition Began? Date:____/____/____

Is it Related to an Auto Accident? No Yes Date of Accident ____/____/____

Is it Non-Work Related Accident? No Yes Date of Accident ____/____/____

Did this Condition Result in Surgery? No Yes If Yes Date of Surgery ____/____/____

Have You Had PT for this Condition? No Yes If Yes
Where?________________________________

Have You Had Chiropractic Services for this Condition? No Yes If Yes Where?________________________________

(4) Patient's Doctor: Please list the Doctor who referred you to therapy below.

____ **Office Phone:** (____) _____-_______
Referring Dr's Name: Last First Initial MD, DO, DDS, Other

____
Address: Street City,State Zip Code

All Patients or Patients' Legal Representative Please Sign Section 11 on Page 3

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(5) If Filing Insurance : Check A or B

A. ____ **Patient is the insured** (Do not need to complete the rest of #5 or any of #6)

B. ____ **Insured is** ___**Spouse** ____**Parent** (Complete all of #5 and all of #6)

____

Name: Last First Initial Sr./Jr.

____

Address: Street Apt.# City State Zip Code

Phone: (___) ____-______ (___) ____-______ (___) ____-______ (___) ____-____
Home Mobile Work Emergency

(6) Insured Person:

Complete if not the patient

Date of Birth: ____/____/____ **S.S. #** ______/_____/_______

Legal ID # ____________ **Insured's Sex: M F**

___ **Employed** ___ **Unemployed** ___ **Retired**

(7) Employer Information (Please complete if the insured person's employer is the source of benefits)

Employer Name: ______________________________________ **Employer Phone # (   )** ______- _______

Address: ____ ____________________
Street City State Zip Code

Name of Employer Contact: ________________________________ **Contact's Phone # (   )** ______- _______

(8) Payor Information:

Primary Insurance Company:

Ins. Co. Name: ____________________ **Insured's Name:** __________________ **Ins. Ph #**________________

Patient ID #: ____________**Group. #** _____________ **Policy/Plan #:** ______________________________

Secondary Insurance Company: (If YES, please complete) **Insured is:** _____**Patient** _____**Spouse** _____**Parent**

Ins. Co. Name: ____________________ **Insured's Name:** __________________ **Ins. Ph#**________________

Patient ID #: ____________**Group. #** _____________ **Policy/Plan #:** ______________________________

Claims Mailing Address:____
Street City State Zip Code

Employer Name: ______________________________________ **Employer Phone # (   )** ______- _______

Address: ____ ____________________
Street City State Zip Code

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(9) Medications : (This includes prescriptions (from your doctor), over the counter drugs, herbal and nutritional supplements)

Separate List Provided Yes No If, No please complete this section

Medication/Drug Name	Dosage	Number of Times Per Day

(10) Payment Authorization to The Center for Balance: *(Initials required for all 3 statements)*

__________ **Assignment of Insurance Benefits**

Initials **I authorize that the payment of my insurance benefits be made directly for all services delivered; if I am paid directly I will promptly pay all monies paid to me**

__________ **Guarantee of Payment**

Initials **I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility' by my insurer by the statement due date**

__________ **Certification of Information**

Initials **I certify that the information I have provided for payment including, but not limited to, Related accidents, illnesses or other insurers is accurate and truthful**

(11) Signature/ Date:

______________________________________ ____________________

Patient or Legal Representative's Signature **Today's Date**

All Patients or Patients' Legal Representative Please Sign Section 11 on Page 3