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

EMAIL ____

(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.

____

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

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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