The Center for Balance
MEDICARE PATIENT & PAYOR INFORMATION FORM
***All* Patients or Patients' Legal Representative, please complete all Sections**

(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: _____

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

Did this Condition Result from a Work Injury? No Yes If Yes Date of Accident ____/____/____

Have You Had PT Anywhere this Year? No Yes If Yes Where?_____

Are You Currently Receiving Home Health? (i.e. any healthcare worker, aide assisting or doing something to or for you?) No Yes If Yes From Who?_____

Do You Live in a Nursing Home? No Yes If Yes What Is Its Name? _____

Are You Covered:

a. Under Black Lung Disease? No Yes
b. End Stage Renal Disease? No Yes
c. Large Group Insurance? No Yes If Yes Name/Group #_____
d. Veterans Affairs No Yes

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

_____

All Patients or Patients' Legal Representative Please Sign Section 9 on Page 2

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(7) 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

(8) Payment Authorization: ***(Initials required for all 3 statements)***

_____ **Assignment of Insurance Benefits**

Initials **I authorize that the payment of my insurance benefits be made directly to LPT for any services that are reimbursable by Medicare or my any other insurance company, if I have one.**

_____ **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 the billing statement due date.**

_____ **Certification of Information**

Initials **I certify that the information I have provided LPT for payment under the Social Security Act (Medicare) including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.**

(9) Signature/ Date:

_____ _____

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

All Patients or Patients' Legal Representative Please Sign Section 9 on Page 2