INSURANCE INFORMATION

(PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST TO COPY OR FILL OUT TOP PORTION OF FORM. IF YOU DON'T HAVE INSURANCE, YOU WILL BE REPSONSIBLE FOR THE BILL UNTIL WE RECEIVE ONE. IF WORKER'S COMP, SEE APPROPRIATE SECTION OR PROVIDE INFO.)

Person responsible for payment if not patient- Name, Street, City, State, Zip Code, and Phone #:

_____

PRIMARY INSURANCE INFORMATION (or provide card)

Name of Insured _____ _____ ____ /____ /_____
(As it appears on card) Relationship Birthdate

Name of Insurance: _____ Insurance Phone #: _____

Policy #: _____ Group #: _____ SSN#: _____

SECONDARY INSURANCE INFORMATION (or provide card)

Name of Insured _____ _____ ____ /____ /_____
(As it appears on card) Relationship Birthdate

Name of Insurance: _____ Insurance Phone #: _____

Policy #: _____ Group #: _____ SSN#: _____

ACCIDENT / WORK INJURY INFORMATION (provide Work Comp info if available)

Were you injured on the job? YES/NO Date of injury: ____ /____ /_____

Accident? YES/NO AUTO/OTHER Date of accident: ____ /____ /_____ Attorney: _____

Employer _____ Work #:_____

Contact/Case manager: _____ Case number #: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to Tallgrass Balance, Hearing & Physical Therapy, LLC. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or Intermediaries or carriers any information needed for this or a related Medicare claim/other insurance company claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

If you don't have insurance coverage, payment is due when service is rendered unless you make arrangements prior to the visit.

I authorize the release of my medical records to my referring physician and/or specialty physician as deemed necessary.

I understand that by signing this form I am giving consent for treatment by Tallgrass Balance, Hearing & Physical Therapy, LLC.

SIGNATURE_____ DATE_____

PARENT/GUARDIAN IF PATIENT UNDER 18 _____