Health Insurance and Patient Information

It is the policy of **Mobile PT LLC** to bill your primary (and secondary if applicable) insurance policies for you. **Mobile PT's** services are typically covered by most health insurance policies. However, there are variances in benefits among insurance companies, and not all services will always be covered by every company. Should prior authorization or a referral be required by your insurance provider, it is your responsibility to ensure that the process has been initiated and completed. Any fees not covered by your insurance are your responsibility.

Please contact your insurance company and fill out the following Patient Information, including the Insurance Benefits Questionnaire and Medical Insurance Information Summary.

Patient Information

Where did you hear about In Mobile PT? ____________________

Name____________________

Birth date__________ Male Female Marital Status: Single Married Other

Address____________________

City/State/Zip____________________ Home Phone____________________

Cell Phone____________________ Work Phone____________________

Email Address____________________

Employer/School____________________ Employer Address (city)____________________

Emergency Contact Name____________________ Emergency Contact Relationship__________

Occupation / Tasks____________________ Emergency Contact Phone____________________

Date of Injury / Onset of Condition__________ Nature of injury/condition__________

Is your injury/condition related to: your job? a car accident? other?

Person Responsible for Bill *(if different from patient)*

Name____________________ Home Phone____________________

Address____________________ Work Phone____________________

City/State/Zip____________________ Relationship____________________

Insurance Benefits Questionnaire

The following information was given to me by (Name of Customer Service Representative):

Date:

These questions should cover ***most*** cases:

1. Does my policy cover physical therapy? Yes No
2. Do I need a prescription for physical therapy? Yes No
3. Do I need a referral to physical therapy? Yes No
4. If yes (to 2 or 3 above), should the prescription/referral come from my primary care provider? Yes No
5. Do I need pre-authorization? Yes No
6. Who requests the pre-authorization?____________________________________
7. Is Mobile PT contracted with this insurance company? Yes No
8. Is there a limit to my physical therapy benefits? Yes No
9. What are the limits to my physical therapy benefits? ____________________________

   Maximum dollar amount $______________(or) Maximum number of visits/units? ________________

1. Are there restrictions or changes after the maximum has been reached? Yes No

   If yes, what are they? ____

2. How much of my physical therapy benefits have I used to date? ____________________________
3. Am I responsible for a percentage of my bill? Yes No _____ %
4. Do I have a co-pay for physical therapy? Yes No $_____
5. What is my deductible? _______________ And how much have I met? ____________________________

Medical Insurance Information Summary:

Insurance Company______________________________ Ins. Phone # ______________________________

Subscriber ID #_________________________________ Group No.________________________________

Subscriber Name________________________________ Co-Pay Amount____________________________

Subscriber Address____

Subscriber DOB ________________________________ Subscriber Phone #_________________________

Subscriber's Employer & Phone #____

Your relationship to subscriber____

Physician______________________________________ Doctor's referral? Yes No

Physician's Address & Phone # ____

I hereby assign all medical benefits to which I am entitled to **Mobile PT LLC** in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 2% per month (24% annually) for unpaid balances over thirty days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of **Mobile PT LLC** as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.

Patient Signature: Date: