INSURANCE INFORMATION

Primary Policy

Insurance Company _____

Insurance Co Address _____

City, State, Zip _____

Name of Policy Holder _____ Relationship _____

SSN _____ Date of Birth _____

Policy / ID # _____ Group # _____

Insurance Co Phone # _____

Is this insurance through a local union? YES NO Is Preauthorization required? YES NO

Have you verified your therapy benefits with your insurance: Yes ___ No ___ **We strongly encourage you to do so**

Secondary Insurance Policy (Please complete if applicable)

Insurance Company _____

Address _____

City, State, Zip _____

Name of Policy Holder _____ Relationship _____

SSN _____ Date of Birth _____

Policy / ID # _____ Group # _____

Insurance Co Phone # _____

I certify that the insurance information above is accurate for me or my dependent being treated at Back To Health PT, LLC. I agree to forward all insurance benefits, if any, directly to Back To Health PT, LLC. I also understand that I am responsible for all charges whether they are or are not covered by insurance. This applies to all of my insurance submissions.

Print Name _____ **Today's Date** _____

Responsible party Signature _____

WORK OR AUTO ACCIDENT INFORMATION (Please complete if applicable)
Are you being seen for treatment due to an approved work or auto accident claim? Yes No