Physical Therapy & Sports Medicine

INSURANCE AGREEMENT

- I authorize payment of medical benefits from my insurance to Integrative Physiotherapy and the release of any medical information relating to all claims for benefits submitted on behalf of myself and/or dependents. I understand that I am responsible for all charges, including those not covered by my insurance, finance charges for balances >30 days (1.5% interest fee) or returned checks ($15), and for any charges incurred due to collections proceedings, attorney's fees or court costs.

Please fill out the following information to use Health Insurance or Worker's Compensation

**Please present your insurance card for verification*

Insurance Company______________________________ ID #___________________________ Group #:________________________

Subscriber name *(if policy is under a parent/spouse)*____________________________________ Subscriber DOB__________________

Please fill out the following for Motor Vehicle Accident related treatment

** Please see office for additional MVA forms*

Date of Accident ________________

Auto Insurance Company_________________________ Policy #_________________________ Claim #_________________________

Policy Holder name______________________________ ☐ Spouse ☐ Parent ☐ Other Driver ☐ Other____________________

Do you have Med-pay ☐ Yes ☐ No

By signing below you have read, understand, and agree to the above conditions of this agreement.

____________________________________	________________________________	____________________
Patient/Responsible Party Signature	Printed Name	Date

OR

NON-INSURANCE AGREEMENT

- This agreement allows you to pay a reduced fee which must be paid in full at the time of service. This agreement is extended to those who have a high deductible or out of network insurance plan. We will not be liable for filing claims with any health insurance company, we will not generate a claim form, nor will we be supporting medical necessity or writing reports.

- Unpaid balances >30 days will be subject to interest charges (1.5%) and a returned check will result in a finance charge of $15. You will be responsible for any charges incurred due to collections proceedings, attorney's fees or court costs.

By signing below you have read, understand, and agree to the above conditions of this agreement.

____________________________________	________________________________	____________________
Patient/Responsible Party Signature	Printed Name	Date