



BILLING INFORMATION/POLICY

Body Dynamic will bill your primary insurance for physical therapy services on your behalf. We expect to be paid by you or your insurance company within 45 days. During that time, we will re-bill one additional time if a denial is received, after which time, you will be responsible for the unpaid balance. We will assist you by providing you with claim forms, so that you may re-bill your primary insurance or bill your secondary insurance. We do not bill for secondary insurance policies or third party payers.

It is your responsibility to provide complete insurance information. Please provide us with a current insurance card so that we may investigate and confirm your coverage. It is your responsibility to know your insurance benefits and any plan limitations your carrier may have. Please contact your insurance company and ask them about your benefits. If your insurance changes at any time while undergoing treatment, it is your responsibility to notify Body Dynamic of those changes and provide us with your new card.

It is also important to remember that health insurance coverage varies and not all services are covered. If your insurance carrier rejects a claim or approves only a portion of the amount billed, the balance of the claim is your responsibility.

ASSIGNMENT OF BENEFITS

I authorize payment directly to Body Dynamic for Physical Therapy services I receive. _____ initial

INSURANCE INFORMATION:

Patient name:(First)_____ (Last)_____ DOB _____

Coverage member name:(First)_____ (Last)_____ DOB _____

DL# _____

Insurance _____ Contact _____ Phone # _____

ID# _____ Group # _____

To my knowledge, the above information is correct. I understand the policy as stated above.

Date _____ Signature _____ Printed name _____

Please Do not write below this line

Copy of Insurance card _____ Estimate Co-Pay _____

In-Network: Co-Pay _____ Max # visits/yr _____ Deductible _____ Met _____

Ann. Max Exp _____

Out-of-Network: % _____ Max #visits/yr _____ Additional w/authorization? Yes No

Additional Deductible _____ Met _____ Family Deductible _____ Met _____

Referral MD _____ DX _____ ICD-9 codes _____