Bellefontaine Physical Therapy, LTD. Demographic Information

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Are you currently receiving Ho	ome Health Care	: YN If	yes, which agency?	
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Name of Insurance Company:				
Group #:	I.D./Policy #:			
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Worker's Compensation: (please				
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Place of Employment at time of Case Manager:	P	hone#:(**************************************
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BPT Patient Information

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Motor Vehicle Accident (please complete this section if your injury is result of a motor vehicle accident, even if yo billing your health insurance.)	u are
Date of Motor Vehicle Accident: Claim #:	
Insurance Company to be billed:	
Address:Phone #:	
Attorney's Name: Phone #:	
I request that payment of authorized medical or other insurance company benefits be made to Bellefontaine Physical Therapy, Ltd. (BPT) for any services furnished to me by BPT. I also authorize BPT to release medical information needed to determine these benefits or the benefits payable for releasing. I understand my signature requests that payment be made directly to BPT and authorized releasing of information to the insurer or agency shown. In the Medicare assigned cases, BPT agrees accept the charge determination of Medicare as full charge and the patient is responsible only for deductible, coinsurance, and non-covered services. I also understand that my signature on this form my permission for treatment.	lated the to gives
We are committed to providing you with the best possible care. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. We bill Medicare direct and for your convenience we bill most commercial insurance companies. In order for us to bill your insurance for it is important that we have the most accurate information you can provide. We must emphasize that medical care providers, our relationship is with you, not your insurance company. Please keep in min your insurance is a contract between you, your employer, and the insurance company. And not all services are a covered benefit in all contracts. Though the filing of insurance claims is a courtesy that extend to our clients, all charges are your responsibility to pay in the event your insurance does not provide at the time of service unless payment arrangements have been made with manager or billing personnel. We accept cash, checks, MasterCard, Visa, Discover.	r you, t as nd we ay.
I have read and understand the financial policy above. I agree to give the pertinent information in or for BPT to file the claims with my insurance company. I understand that in the event my insurance company does not pay for services, I am responsible to pay the balance on my account.	der
Signature: Date:	
Patient/Parent/Guarantor	
Notice of HIPPA Privacy Practices	
I,, acknowledge that I have received Bellefontaine Physical Therapy's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of this Notice.	
Signature: Date:	
Signature: Date:	