pt Health
GET WELL. STAY WELL.

Insurance Information Date:_____

Client Name: _____

Client DOB (DD/MM/YYYY): _____

PRIMARY INSURANCE INFO:

Policy Holder Name	
Policy Holder DOB	
Policy/Plan Number	
Contract/ID Number	
Policy Renewal Month	

Service	**PHYSIO**	**MASSAGE**	**CHIRO**	**OTHER-**
Referral Required	**Y N**	**Y N**	**Y N**	**Y N**
Max Per Year				
Covered at %				

SECONDARY INSURANCE INFO (if applicable):

Policy Holder Name	
Policy Holder DOB	
Policy/Plan Number	
Contract/ID Number	
Policy Renewal Month	

Service	**PHYSIO**	**MASSAGE**	**CHIRO**	**OTHER-**
Referral Required	**Y N**	**Y N**	**Y N**	**Y N**
Max Per Year				
Covered at %				

Billing Options (please check):

○ 1. I agree to have the clinic direct bill my insurance plan. All information and forms have been given and signed. I fully understand the policy for direct billing.

○ 2. I prefer to pay upfront and submit my treatment receipts on my own.

I have read the above information and fully understand the billing policy.

Client Signature:

_____