
MCMEEN PHYSICAL THERAPY CLINIC

INSURANCE INFORMATION SP IS DI BC



PRIMARY INSURANCE (See copy of insurance card)

Insurance Company: _____

Address: _____

Group #: _____

Employee #: _____

Insured Name: _____

Relationship to patient: _____

Insured DOB: ____ / ____ / ____

Insured SS #: _____ - _____ - _____

Insured Occupation: _____

Insured Employer: _____

SECONDARY INSURANCE (See copy of insurance card)

Insurance Company: _____

Address: _____

Group #: _____

Employee #: _____

Insured Name: _____

Relationship to patient: _____

Insured DOB: ____ / ____ / ____

Insured SS #: _____ - _____ - _____

Insured Occupation: _____

Insured Employer: _____

AUTHORIZATION AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or the other health practitioners.

I authorize and request my insurance company, including liability insurance, to pay directly to McMeen Physical Therapy, P.C. of Broken Bow benefits otherwise payable to me, but not to exceed the clinic's regular charges for services.

I understand that if a settlement or law suit is pending regarding my injury, I am responsible to make a reasonable monthly payment on my account until the balance is paid in full. McMeen Physical Therapy of Broken Bow will not agree to bill an attorney for services rendered in our facility.

I understand that MPTS is a participating member of Medicare, Blue Cross/Blue Shield of Nebraska and PPO member, Medicaid of Nebraska, Champus, Mutual of Omaha and Heartland Comprehensive.

I understand that I am responsible to read my insurance policy or contact my agent regarding specific provisions of my policy relating to Physical Therapy services (i.e. need of a physician's referral, number of visits, pre-authorization, etc.) as coverage is unique to each policy.

I understand that it is fraudulent to attempt to file a Workman's Comp. Claim with my private health insurance company.

I understand that I am responsible for payment of all services rendered on my behalf or my dependents, to keep the account current and to settle any discrepancies with my insurance company personally.

Signature of Patient or Parent if Minor

Date

(This consent for above will be in effect for this admission and until all claims are settled)