
MCMEEN PHYSICAL THERAPY CLINIC

INSURANCE INFORMATION MC MM



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 during the period of such care to third party payors, Health Care Financing Administration and/or other health practitioners.

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

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 must have a physician's referral in order for claims to be submitted to Medicare and I understand that I am responsible for the entire balance on my account if no physician referral is given.

I understand that I will not receive a statement from MPTS, unless otherwise requested, or unless a balance is due after insurance.

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 after insurance has paid their portion or they have given their explanation of benefits.

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)