
MCMEEN PHYSICAL THERAPY CLINIC

INSURANCE INFORMATION Workmen's Comp

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 IN THE EVENT OF A DENIAL

I understand that in the event that Workmen's Comp. should deny my claims, I am responsible for the payment of the entire balance in a timely fashion and to settle any discrepancies with the Carrier personally.

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, and/or other health practitioners.

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

I understand that I am responsible to read my insurance policy or contact my agent regarding specific provision of my policy relating to McMeen Physical Therapy, P.C. services.

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)