HEALING MOTION
PHYSICAL THERAPY

FINANCIAL POLICY AND INSURANCE INFORMATION

I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am responsible for all charges regardless of my existing medical coverage. I understand that I am responsible for all supplies, such as braces or exercise equipment, which I am provided during treatment, if they are not covered by my insurance plan. I understand that I will pay for supplies upon receipt and Healing Motion Physical Therapy (HMPT) will bill my insurance company and refund me any monies received by them from my insurance company for said supplies. I hereby give authorization for payment of insurance benefits to be made directly to HMPT for services rendered. In the event that my insurance company forwards payment directly to me, instead of HMPT, I will immediately deliver said payment to HMPT.

I understand and agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due, upon demand. I understand and agree that if it becomes necessary for HMPT to utilize an outside collection agency or to commence court action, for the collection of any outstanding charges, I will be responsible for the outstanding balance.

Signature of Person Responsible for Charges: _____ Date: _____
Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient, **if patient is under 18 years of age** ○ Mother ○ Father ○ Legal Guardian

PRIMARY INSURANCE

Name of Subscriber: _____ Birthdate: _____/____/_____

Relationship to Patient: ○ Self ○ Spouse ○ Parent Other: _____

Address of Subscriber: _____
(If Different than Patient) Street Address City State Zip Code

Home Phone: (____) _____-_____Cell Phone : (____) _____-_____ SS #:_____-____-_____
(If Different than Patient)

Insurance Co: _____ Phone: (_____) _____-_____

Subscriber #: _____ Group #/Name: _____

Subscriber's Employer: _____ Phone:(_____) _____-_____

SECONDARY INSURANCE ***If you have NO Secondary Coverage Initial Here (_____)

Name of Subscriber: _____ Birthdate: _____/____/_____

Relationship to Patient: ○ Self ○ Spouse ○ Parent Other: _____

Address of Subscriber: _____
(If Different than Patient) Street Address City State Zip Code

Home Phone: (____) _____-_____Cell Phone : (____) _____-_____ SS #:_____-____-_____
(If Different than Patient)

Insurance Co: _____ Phone: (_____) _____-_____

Subscriber #: _____ Group #/Name: _____

Subscriber's Employer: _____ Phone:(_____) _____-_____