Verification of Insurance / Benefits

Verification of benefits is not a guarantee of payment and financial responsibility is subject to change.

Your primary health insurance carrier had verified that you have a $ _____yearly deductible of which $_____ has been met.

After your deductible has been satisfied, your insurance carrier **estimates** your therapeutic benefits are covered at _____%.

You have an **estimated** responsibility of $ _____ or %_____due at each visit.

Your insurance company has advised us that your policy has the following limitations:

In order to ensure that we are filing the correct insurance please answer the following questions.

1. Injury related to an auto accident? **Yes / No** If Yes, Name of Auto Insurance Company: _____
2. Do you have legal representation (attorney)? **Yes / No** If Yes, please complete attorney information below:
   Attorney Name: _____ Name of Law Practice: _____
   Address: _____ Phone Number: _____
   Do you have a letter of exhaustion from your Auto Carrier? **Yes / No** Can you provide us with a copy? **Yes / No**
   Do you have a medical / health insurance? **Yes / No** If Yes, Name of Health Insurance Carrier
   Insurance Company Name: _____ Phone Number: _____
   Name of Primary Insured: _____ ID number: _____
3. Injury related to a work accident? **Yes / No** If Yes, Name of Employer and address at time of injury:
   Employer Name: _____ Address: _____
4. Have you received therapy for the same illness / injury in the last year? **Yes / No**
   If Yes, name of facility: _____ Dates Treated: _____
5. Are you (or have you) currently receiving any type of Home Health services? **Yes / No**
   Name of Home Health Agency: _____ Date Discharged: _____
6. Name of physician who referred you to therapy: _____ Phone: _____
7. Name of primary care physician: _____ Phone: _____

Benefits that we have received from your insurance carrier at the time of service are not a guarantee of benefits. The patient, legal guardian or parent (if the patient is under 18 years old) will be responsible for the co-payment and the deductible at the time of service.

_____
Name of Patient

_____ _____
Patient/Guardian Signature **Relationship to Patient**

_____ _____
Print Name **Date**