MEDICARE PATIENT & PAYOR INFORMATION FORM

***All* Patients or Patients' Legal Representative, please complete all Sections**

The Center for Balance

(1) Patient: (Full Legal Name or as on Insurance Card)

Name: Last First Initial Sr. Jr.

Address: Street Apt# City State Zip Code

Phone: (_____) _____-_____ (_____) _____-_____ (_____) _____-_____ (_____) _____-_____
Home Mobile Work Emergency

(2) Patient **Sex: M F** **Birthdate: _____/_____/_____**

S.S # _____/_____/_____ **Legal Photo ID # _____**
(Driver's License, Passport, Other State/Federal Photo ID)

(3) Condition to be treated in Physical Therapy: _____

Did this Condition Result in Surgery? No Yes If Yes Date of Surgery ____/____/____

Did this Condition Result from a Work Injury? No Yes If Yes Date of Accident ____/____/____

Have You Had PT Anywhere this Year? No Yes If Yes Where?_____

Are You Currently Receiving Home Health? (i.e. any healthcare worker, aide assisting or doing something to or for you?) No Yes If Yes From Who?_____

Do You Live in a Nursing Home? No Yes If Yes What Is Its Name? _____

Are You Covered:

a. Under Black Lung Disease? No Yes
b. End Stage Renal Disease? No Yes
c. Large Group Insurance? No Yes If Yes Name/Group #_____
d. Veterans Affairs No Yes

(4) Patient's Doctor: Please list the Doctor who referred you to therapy below.

Referring Dr's Name: Last First Initial MD, DO, DDS, Other **Office Phone:** (___) _____-_____

Address: Street City,State Zip Code

(5) Payor Information Primary:

Primary Insurance Company: Medicare

Insured's Name:_____ **Patient ID # _____** **Group # _____**

Regular Medicare: Yes No **Rail Road Medicare: Yes No**

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(6) Payor Information Secondary/Supplemental Insurance Company: (If YES, please complete)

Ins. Co. Name: _____ Insured's Name: _____ Ins. Ph#_____

Insured is: _____Patient _____Spouse _____Parent

Patient ID #: _____Group. # _____ Policy/Plan #: _____

Claims Mailing Address:_____
Street City State Zip Code

Employer Name: _____ **Employer Phone # ( ) _____- _____**

Address: _____ _____
Street City State Zip Code

(7) Medications : (This includes prescriptions (from your doctor), over the counter drugs, herbal and nutritional supplements)

Separate List Provided Yes No If, No please complete this section

Medication/Drug Name	Dosage	Number of Times Per Day

(8) Payment Authorization to The Center for Balance: *(Initials required for all 3 statements)*

_____ **Assignment of Insurance Benefits**

Initials **I authorize that the payment of my insurance benefits be made directly for any services that are reimbursable by Medicare or my any other insurance company, if I have one.**

_____ **Guarantee of Payment**

Initials **I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by the billing statement due date.**

_____ **Certification of Information**

Initials **I certify that the information I have provided for payment under the Social Security Act (Medicare) including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.**

(9) Signature/ Date:

_____ _____
Patient or Legal Representative's Signature **Today's Date**

All Patients or Patients' Legal Representative Please Sign Section 9 on Page 2