

Advanced Motion Therapeutic Massage, Inc.
Insurance Verification

Patient Intake Information:

Patient: (First, Middle Initial, Last) _____
SS# _____
DOB: _____ Age: _____ Gender: Male or Female Race: W B H A Other
Address: _____ Phone: _____
Patient Employer: _____ Phone: _____
Patient Diagnosis: _____

Physician Information:

Referring Physician: _____ Address: _____
Phone: _____ Fax: _____
Medicare: Yes or No Medicaid: Yes or No Insurance code: _____
MC # _____
Insurance CO: _____ Phone: _____ Fax: _____
Address: _____
Type of policy: HMO PPO GRP WC AUTO Effective date: _____
Policy # _____ Group # _____
Claim # _____
Secondary Group #: _____ Phone: _____ Fax: _____
Address: _____
TYPE OF POLICY: HMO PPO GRP WC AUTO Effective Date: _____
Policy # _____ Group# _____
Claim # _____
Name of person verifying benefits: _____ Title: _____
Deductible: _____ Pre-existing cause: Yes or No
Coverage: _____
Limits: _____
Exclusions: _____
Insurance verified by: _____ Date: _____
Patient will be responsible for: _____

Additional Information:

Services Requested: OT PT SP Other _____
Amount of therapy authorized: _____
Frequency/Duration of Therapy (ies): _____
Medical Records requested: Yes or No Date of Referral: _____

Patient Responsibilities under Declared Coverage:

Please be advised that the accuracy of the above information is dependent on the statements of coverage made by representatives of your insurance company. Your insurance company has informed us that this is not a guaranteed benefit.

Final patient responsibility or balance will be billed to the patient, after all the insurance monies have been received. Delinquent accounts 90 days past due will be sent to a collection agency. If you need any assistance to arrange payment, or if you have any questions concerning your account, please call our Business office at (772) 567-8585.

Once you have reviewed the above, and fully understand the outline of your coverage, please sign below.

Please Print Your Name
(As it appears on your insurance card)

Your Signature

Date

Witness Name

Witness Signature

Date