(OFFICE USE ONLY)
THERAPIST_____
REFERRING DOCTOR_____
INJURED AREA_____
ICD-9_____

body in balance physical therapy
2828 W. 44th Ave., Denver, CO 80211
303-477-5303

PLEASE CALL 24 HOURS IN ADVANCE IF YOU NEED TO RESCHEDULE YOUR APPOINTMENT

PATIENT NAME_____ SSN_____

ADDRESS_____ CITY_____ ZIP_____

PRIMARY PHONE_____H W C SECONDARY PHONE_____H W C

DOB_____ AGE_____ MARITAL STATUS_____ OCCUPATION_____

E-MAIL ADDRESS_____

EMERGENCY CONTACT_____ RELATION_____ PHONE_____

How did you hear about Body in Balance PT? _____

PLEASE PRESENT YOUR INSURANCE CARD AND I.D. TO THE OFFICE STAFF FOR PHOTOCOPYING

Is your injury: Work Related Auto Related Other Date of Injury or Surgery_____

Responsible Party: Self Spouse Guardian Other

Primary Insurance_____ Insurance Phone_____
Adjuster_____Insured Name_____ Insured DOB_____
ID#_____ Group Name_____
Secondary Insurance_____

Consent to Treat: I authorize Body In Balance Physical Therapy to render services as deemed necessary for the care of the above named Patient.
Medical Release of Information: I authorize Body In Balance Physical Therapy to release any medical information necessary to process this claim.
Assignment of Benefits: I hereby assign payment directly to Body In Balance Physical Therapy, the basic benefits as well as major medical benefits herein specified and otherwise payable to me, for the charges for this treatment period. I understand I am financially responsible for any charges not covered by my insurance. I understand that I will be held responsible for any costs incurred regarding collection of payment services rendered.
HIPPA Notice of Privacy Practices: I have read and understand my rights outlined in the HIPPA notice of privacy Practices as patient at Body in Balance Physical Therapy.

CANCELLATION POLICY: If you are unable to attend your scheduled appointment, we would appreciate at least 24-hour notice. No showing or canceling your appointment with less than 24-hour notice may result in a $60 charge.

The cancellation charge is not covered by your insurance policy and will be your responsibility.

FOR YOUR CONVENIENCE, WE ACCEPT CASH, CHECKS, VISA AND MASTERCARD

Patient Signature_____ Date_____ Staff Init_____

A FINANCE CHARGE OF 10% WILL BE ASSESSED MONTHLY FOR ANY UNPAID BALANCE