**ELITE PHYSICAL THERAPY**

**7600 SW 57th Ave. Suite PH 304 South Miami, Florida 33143**
**Tel # 305-667-1918 Fax #786-534-5730**

# INSURANCE INFORMATION

**FOR YOUR CONVENIENCE, WE WILL VERIFY YOUR INSURANCE BENEFITS. Please provide us with the following information.**

## MAJOR MEDICAL INSURANCE

**Primary Insurance _____ Phone # _____**
**Policy Holder/Subscriber _____ Policy # _____**
**Relationship to Insured _____ Group # _____**
**Subscriber DOB _____ Patient DOB _____**
**Insured through Employer/Group _____**

**If your complaints are related to an accident, please be sure to let us know. Indicate below accordingly.**

## ACCIDENT: AUTO/WC/SLIP & FALL

**Insurance Company _____ Tel # _____**
**Claim # _____ DOA _____**
**Adjuster's Name _____ Tel # _____**
**DESCRIBE ACCIDENT _____**

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**Are you receiving or have you received treatment for this accident? If yes, provide details.**

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Authorization to Release/Obtain Information: I hereby authorize the release of any and all information to my insurance company or other appropriate part, as required, pertaining to treatment rendered to me by Elite Physical Therapy. Further, I authorize Elite Physical Therapy to obtain needed information from my physician, employer, or insurance company. Consent to Treatment and Financial Responsibility: I hereby understand and fully agree that (regardless of my insurance status) I am ultimately responsible for any balance owned to Elite Physical Therapy (William J. Reader, PT) for any medial services rendered to me, including any unfulfilled deductible amount and/or co-insurance on my insurance plan. I also understand that any balance not paid after 30 days will be charged finance fees as allowed per state (% subject to change). Furthermore, I also understand that should my account be transferred to a collections agency or attorney for collective action, I will be responsible for the principle amount and any collection fees, if any. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. I do hereby consent to such treatment by the authorized personnel of Elite Physical Therapy. This content is intended as a waiver of liability for such treatment except for negligence. If a patient is a minor parent must sign this form and consent to treatment. Otherwise, services cannot be rendered by State Laws. I have read and understood all the above and I certify that this information is true and correct to the best of my knowledge. Also, I will notify Elite Physical Therapy if any of the above information changes during my treatment. Notice of Information Practices I acknowledge that I have been shown the posted notice of information practices by Elite Physical Therapy.

**Signature of Patient or Parent/Guardian: _____**

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**Date: _____**