body | balance realign. reconnect. recover.

Health Insurance

Name: ______________________________ Today's Date: ______________

Address: ____

Number Street City State Zip

Date of Birth: ____________ Marital Status: ______________ Number of Children: ______

Gender identity/preferred pronoun(s): ______________________________________

Email: ____

Only for occasional communication from our office, circle one: Opt IN Opt OUT

Primary Phone: ________________________ Home Cell Work Preferred

Secondary Phone: ______________________ Home Cell Work Preferred

Emergency contact: ____________________ Phone: ____________________

Occupation: __________________________ Employer: __________________

Insurance company name: ____

Billing address: ____

Number Street City State Zip

Billing fax # ______________________ Billing email: ______________________

Policy # __________________________ Group # ___________________________

Customer Service Phone: ______________ Provider Relations Phone: ______________

************Complete ONLY if the patient is not the insured.************

Insured's name: ____________________________ Insured's date of birth: __________

Insured's address: ____

Number Street City State Zip

Insured's phone: __________________________ Insured's relationship to patient: __________

As a courtesy, Body Balance Rolfing and Massage, LLC (Body Balance) will verify and bill your insurance coverage for all services rendered. Deductibles, co-payments, and co-insurance are your responsibility.

FINANCIAL RESPONSIBILITY: For and in consideration of the treatment to the patient, I promise to pay all charges for services rendered to or on behalf of the patient. If the assigned insurance denies payment, I promise to pay the balance due upon notification. Any unpaid balance that is over 60 days old will be referred to Collections for accounts receivable assistance. I will bear the cost of collection and/or court costs and reasonable legal fees should this be required.

ASSIGNMENT OF BENEFITS: I authorize my insurance/benefits carrier(s) to remit payment of benefits for any claim to Body Balance. I understand that any ineligible/not covered charges are my responsibility. I authorize Body Balance to release any information necessary to process medical claims.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered to be as valid as the original. I have read, understand, and agree to the above.

Signature: ______________________________ Date: ________________