INSURANCE INFORMATION /ASSIGNMENT of BENEFITS

INSURANCE INFORMATION:

Date:_____

Patient Name:_____

Insured's Name:_____

SS#/ID#:_____

_____

Employer:_____

Primary Insurance Subscriber's Full Name: _____

Primary Insurance Subscriber's D.O.B _____ Relationship to patient _____

Primary Insurance Carrier: _____

ID#: _____ Group #: _____

Insurance Co. Address: _____

Phone #: _____

Secondary Insurance Subscriber's Full Name: _____

Secondary Insurance Subscriber's D.O.B _____ Relationship to patient _____

Secondary Insurance Carrier: _____

ID#: _____ Group #: _____

Insurance Co. Address: _____

Phone #: _____

14M Worlds Fair Drive, Somerset, New Jersey 08873
Phone 732-356-5363 ● Fax 732-356-5364
www.ChildrensTherapySource.com

I understand that Children's Therapy Source will bill my insurance company and I have provided all necessary information. I authorize payment of benefits directly to Children's Therapy Source. I understand I am to pay all deductibles, co-payments, and supply items at time of service. I agree that after 60 days all balances due to Children's Therapy Source become my responsibility. Children's Therapy Source will accept partial payments without losing our rights under this agreement.

I authorize my insurance company, organization, employer, hospital, or healthcare provider to release any information requested with regards to processing my claims. I certify that the information furnished on this form is true and correct and know that it is a crime to use false information or purposely leave out facts regarding my insurance.

Deductibles and co-payments are due from the patient at time of service. We must have an assignment of insurance benefits for your patient account for all services not paid in full at time of service. We will gladly assist you with financial arrangement or review your insurance coverage. Worker's compensation claims must be verified with both the employer and insurance carrier. Claims not verified are the financial responsibility of the patient and are payable at the time of service. Refunds will be available when the insurance has settled the account. Automobile accident claims must be party liability claims. Veterans Administration patients must pre-authorize their treatment with the VA, prior to any visit. Any treatment or supplies provided prior to authorization is the responsibility of the patient at time of service. If your account is referred to a collection agency an additional fee will be added to account for collection agency fees.

I understand and agree to the above financial policies of Children's Therapy Source.

ASSIGNMENT of BENEFITS:

I hereby instruct and direct the above insurance company to pay by check made out and mailed to:
Somerset Family Physical Therapy
14M World's Fair Dr
Somerset, NJ 08873
for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay, in a current manner, any balance of said professional service charges as defined by my insurance coverage and/or over and beyond this insurance payment.
A photocopy of this agreement shall be considered as effective and valid as the original.
I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney on my behalf.

Signed: _____ Date: _____

Relationship to Patient: _____