Insurance Information

Infinity Physical Therapy
1404 Fifield Road
Pella, Iowa 50219
641.621.0044

Patient Name ______________________________

Birth Date ______________________

Insurance ______________________ Secondary ________________

Policy Number ___________________ Policy Number ________________

Provider Phone Number ___________________

Policy Holder ____________________________

Co-pay/Co-Insurance ____________

Deductible ______________________

Number of visits per year ___________________

Approximate charges per visit ________________

Have you had physical therapy this year? ☐ Yes ☐ No

Number of visits? ____________

Medicare Patients

Are you currently receiving Home Health Care? ☐ Yes ☐ No

Workers Compensation:

Employment ______________________________

Insurance ______________________________

Address ______________________________

Claim Number ______________________________

Case Manager ______________________________

- I understand my insurance benefits as they are explained above and that this estimate does not guarantee payment by my insurance company.
- Infinity Physical Therapy may receive payment from my insurance, but if I have not provided insurance information I will be responsible for payment.
- I agree to pay my co-pay, co-insurance, and deductible at each date of service.
- Infinity PT may release medical information to my insurance company.
- My medical/financial information may be discussed with:

____

Please flip over to complete

Payment Information/Health Savings Information

☐ Check ☐ Cash ☐ Credit Card ☐ Other

Name on Card ______________________________

Type of Card ☐ MasterCard ☐ Visa ☐ Discover ☐ Other

Card Number ______________________ Expiration Date ____________

Please charge my card for any balances at the end of the billing month

☐ Yes ☐ No

- Knowing your health insurance benefits is your responsibility.
- We encourage you to contact the insurance companies customer service department to verify your physical therapy coverage, and to ask about additional questions you may have.
- We will verify your insurance coverage and benefits with your insurance company. This is only an estimate.
- We will file claims with your insurance company.
- If payment is delayed, reduced, or denied you will be responsible for your balance.

______________________________ ____________

Signature of Patient or Legal Guardian Date

Thank you for choosing Infinity Physical Therapy!
We look forward to serving you!