COMMERCIAL INSURANCE INFORMATION

All Patients or Patients' Legal Representative, please complete all sections

1. Patient Information (Full Legal Name or as on Insurance Card)

Last	First	Middle	
Street Address	City	State	Zip Code
Phone Number ☐Home ☐Mobile ☐Work	Alternative Phone # ☐Home ☐Mobile ☐Work	Email*	
Date of Birth (MM/DD/YY)	Legal Sex**	How would you like to receive appointment reminders? ☐Call ☐Text ☐E-Mail	

2. If Filing Insurance: Check A or B

A. ☐ Patient is the one who is Insured (Skip to Section 3)

B. Insured is: ☐ Spouse ☐ Parent (Fill information below)

Last	First	Middle Initial	Gender	Date of Birth
Street Address	City	State	Zip Code	
Phone Number: ☐Home ☐Mobile ☐Work				

3. Payor Information

Primary Insurance	Insured's Name	Insurance Phone #
Patient ID #	Group #	Policy/Plan #
Secondary Insurance	Insured's Name	Insurance Phone #
Patient ID #	Group #	Policy/Plan #

4. Credit Card Payment Authorization (If Applicable)

I hereby authorize Kinetic Physical Therapy and Wellness/Kinetic Pediatric Therapy to charge my credit card for services rendered and/or products supplied until this authorization is revoked by me. It is my responsibility to notify Kinetic of any changes regarding this credit card authorization.

Name on Card	Credit Card Type: ☐ Mastercard ☐ Visa ☐ American Express ☐ Discover		
Credit Card Number	Exp Date	Security Code	Billing Zip Code

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Signature	Date	Would you like an e-mail receipt with each transaction? ☐ Yes ☐ No

5. Employer Information (Please complete if the insured person's employer is the source of benefits)

Employer Name		Employer Phone Number	
Street Address	City	State	Zip

6. How Did You Hear About Kinetic Physical Therapy and Wellness? (Select One Answer Only)

☐ Doctor	☐ I am a Returning Patient	☐ General Online Search
☐ My Insurance Network	☐ Yelp!	☐ Other (Please Describe):
☐ Friend or Family	☐ Google Maps/Reviews	_____
☐ Walked by/in	☐ Social Media (Facebook, Instagram, Twitter)	_____

7. Release, Assignment, and Guarantee of Payment

Initial	**Assignment of Insurance Benefits:** I Authorize that the payment of my insurance benefits be made directly to Kinetic Physical Therapy and Wellness for all services delivered; if I am paid directly, I will promptly pay Kinetic Physical Therapy and Wellness all monies paid to me.
Initial	**Guarantee of Payment:** I understand that all payments designated as 'the patient's responsibility' such as co-insurance and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed 'my responsibility' by my insurer by the statement due date.
Initial	**Certification of Information:** I certify that the information I have provided Kinetic Physical Therapy and Wellness for payment including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.
Initial	**Permission to Release Information:** I hereby authorize any holder of medical or other information about me to release all medical records, financial records, and other information needed by Kinetic Physical Therapy and Wellness to provide services or to secure payment for services to Kinetic Physical Therapy and Wellness. I also authorize Kinetic Physical Therapy and Wellness to release any medical records, financial records, and information to any of my payment sources, including my attorney if applicable, or to the referring agency, physician, or caseworker. I agree that this authorization is irrevocable and is in effect until services are paid in full. Release of information to entities other than those identified above, such as other providers, requires the completion of a *Consent for the Release of Information Form* which identifies the Intended recipient of specified information. Information will not be released without appropriate signed consent unless required by state or federal laws. A *Consent for the Release of Information Form* is valid for the duration of the admission, or until revoked by the patient or responsible party, or until the expiration of one year. I give unrestricted permission for my information to be released to the referring physician or provider case manager.

8. I attest, to the best of my knowledge, the above information is true and accurate

Patient or Legal Representative Signature	Date

**May be used for your appointment reminds, home exercise programs, response inquiries, and/or other Kinetic updates.*
***Please be aware that your name and sex listed on your insurance must be used on documents pertaining to insurance billing and correspondence.*