

## COMMERCIAL INSURANCE INFORMATION

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

<b>1. Patient Information (Full Legal Name or as on Insurance Card)</b>					
Last	First	Middle			
Street Address		City	State	Zip Code	
Phone Number <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work		Alternative Phone # <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work		Email*	
Date of Birth (MM/DD/YY)		Legal Sex**	How would you like to receive appointment reminders? <input type="checkbox"/> Call <input type="checkbox"/> Text <input type="checkbox"/> E-Mail		
<b>Are you / the patient receiving therapy services anywhere else?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If so, Where?</b> _____					
<b>2. If Filing Insurance: Check A or B</b>					
A. <input type="checkbox"/> Patient is the one who is Insured      OR      B. Insured is: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent (Fill information below)					
Last	First	Middle Initial	Gender	Date of Birth	
Street Address		City	State	Zip Code	
Phone Number <span style="float: right;"><input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work</span>					
<b>3. Payor Information</b>					
Primary Insurance		Insured's Name		Insurance Phone #	
Patient ID #		Group #		Policy/Plan #	
Secondary Insurance		Insured's Name		Insurance Phone #	
Patient ID #		Group #		Policy/Plan #	
<b>4. Credit Card Payment Authorization (If Applicable)</b>					
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: <input type="checkbox"/> Mastercard <input type="checkbox"/> Visa <input type="checkbox"/> Amex <input type="checkbox"/> Discover		
Credit Card Number		Exp Date	Security Code		Billing Zip Code
Signature			Date	Would you like an e-mail receipt with each transaction? <input type="checkbox"/> Yes <input type="checkbox"/> No	

## COMMERCIAL INSURANCE INFORMATION

<b>5. Physician Information</b>			
What Physician referred you to Kinetic?		What is the name of the Physician's practice?	
Is the above Physician your Primary Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, please list your primary physician below:	
<b>6. Employer Information (Please complete if the insured person's employer is the source of benefits)</b>			
Employer Name		Employer Phone Number	
Street Address	City	State	Zip
<b>7. How Did You Hear About Kinetic? (Select One Answer Only)</b>			
<input type="checkbox"/> Doctor <input type="checkbox"/> My Insurance Network <input type="checkbox"/> Friend or Family <input type="checkbox"/> Walked by/in	<input type="checkbox"/> I am a Returning Patient <input type="checkbox"/> Yelp! <input type="checkbox"/> Google Maps/Reviews <input type="checkbox"/> Social Media (Facebook, Instagram, Twitter)	<input type="checkbox"/> General Online Search <input type="checkbox"/> Other (Please Describe): <hr/> <hr/>	
<b>8. Release, Assignment, and Guarantee of Payment</b>			
Initial	<b>Assignment of Insurance Benefits:</b> 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	<b>Guarantee of Payment:</b> I understand that all payments designated as 'the patient's responsibility' such as co-insurance and deductibles are due <b>and</b> 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	<b>Certification of Information:</b> 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	<b>Permission to Release Information:</b> 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 <i>Consent for the Release of Information Form</i> 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 <i>Consent for the Release of Information Form</i> 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.		
<b>9. I attest, to the best of my knowledge, the above information is true and accurate</b>			
Patient or Legal Representative Signature		Date	

\*May be used for your appointment reminders, 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.