BILLING INFORMATION/POLICY

Body Dynamic is an “Out-of-Network” Provider. As a courtesy, we will bill your primary insurance on your behalf for physical therapy services rendered. We expect to be paid by you or your insurance company within 45 days from service date. During that time, we will re-bill one additional time, if a denial is received. After which, you will be responsible for the unpaid balance. We will assist you by providing a superbill, so that you may re-bill your primary insurance or bill your secondary insurance. We do not bill third party payers.

Please provide us with a current insurance card and complete insurance information, so we can attempt to determine your coverage. It’s your responsibility to know your insurance benefits and any plan limitations your carrier may have. Please contact your insurance company to confirm benefit coverage. Record your contact person and date so that you may have recourse if there is a problem. If your insurance changes at any time while undergoing treatment, it is your responsibility to notify Body Dynamic of those changes and provide us with your new card. If you are receiving Physical Therapy or Chiropractic treatments from another provider, it is your responsibility to notify us. This may affect your coverage regarding the number of visits allowed and/or billing allowed for Similar services. It is generally not recommended to receive services on the same day as this is often denied and you will be responsible for the charges.

A detailed evaluation is required for the first visit and every 8 – 12 weeks. There is an additional fee for this service.

It is also important to remember that health insurance coverage varies and not all services are covered. If your insurance carrier rejects a claim or approves only a portion of the amount billed, the balance of the claim is your responsibility. We will expect payment at your next visit or within 30 days. It is illegal for us to waive any part of your deductible. Late penalties will accrue after 30 days at a rate of 10% with an additional $40 administrative fee for invoicing.

ASSIGNMENT OF BENEFITS
I authorize payment directly to Body Dynamic for Physical Therapy services I receive. If the insurance company reimburses me directly, I will submit *that same* payment to Body Dynamic within 1 week of it being posted.

INSURANCE INFORMATION:

Patient Name:(First)_________________________(Last)______________________________DOB_______________

Name on Card_____________________________ Relationship: self spouse child other

Coverage Member:(First)______________________(Last)__________________________DOB________________

Best Phone #____________________________ email:____

Insurance__________________________ Contact________________________ Phone #________________________

ID#___________________________ Group #_____________________

To my knowledge, the above information is correct. I understand the policy as stated above.

Signature _____________________________Print Name: ____________________________ Date____________

Please do not write below this line. For Body Dynamic office use only.

Copy Ins. Card?: Y N Pre-Authorization/Coordination: Y N Rx Req.: Y N Separate/Combined

In-Network: Co-Pay__________ Max # visits/Year: ______

Deductible: ______________ Met______________ Annual Max Exp___________

Out-of-Network/Non-Preferred: %__________ Estimate Co-Pay____________ Max # visits/Year: ______

Deductible: _____________ Met: _____________ Family: _____________ Met: ____________