



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 the 2nd submission, 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. When additional information, forms, or chart notes are requested to complete claims, there is a \$100 fee to process the re-submission.

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. Our minimum collected amount is \$350 for the initial evaluation and \$250 for each regular visit. Co-Insurance is determined after EOB is received. Until then, we will collect \$350/\$250 per visit respectively.

Late penalties will accrue after 30 days at a rate of 10% with an additional \$40 administrative fee for invoicing each month.

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: _____