Flex physical therapy and sports medicine

Update 12/2018

Patient Insurance Benefits Summary

Please contact your insurance company by calling the customer service number on the back of your card. It's critical that this form is filled out in its entirety and is brought with you to your 1st appointment.

***Ask your insurance company for the following information regarding your benefits for Physical Therapy in an office setting:**

Insurance Company**:** _____ Dates of coverage**:** _____ to _____

1. Do you have co-pay? YES or NO

   If yes, how much is it? $ _____ (skip to question 4)

   If no, how much is your deductible? $ _____
   How much has been met to date this year? $ _____ (continue to question 2)

2. What is your out-of-pocket maximum? $ _____ How much has been met this year? $ _____

3. What is your co-insurance percentage? _____/_____

4. Do you have a visit limit for physical therapy? YES or NO
   - Soft or Hard Limit? _____

5. If yes, how many visits? _____ How many have you used this year? _____

6. Is authorization for Physical Therapy required? YES or NO

7. If you are not the primary policy holder, fill out information below:

   Name: _____
   Date of Birth: _____
   Relationship to patient: _____

Benefits quoted are not a guarantee of benefits. Benefits will be determined by your insurance company once a claim has been received and processed. I understand I am responsible for any balance due after insurance is processed.

I have read and understand the above benefits.

_____ _____ _____
Printed Name **Signature (parent/guardian must sign)** **Date**

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