Customer Insurance Information

Date: ________/_________/__________

Personal Information:

Name: DOB: Age:

Address:

City: State: Zip:

Email: Phone: cell ☐ home ☐

How did you hear about us?:

Emergency Contact:

Name: Relationship:

Phone: ☐ cell ☐ home Email:

Car Accident ☐ OR Work-comp injury ☐

Date of accident: ___/ ___/______ in which state: ____________

Name of insured person: self ☐ other: __________________________________

If car accident were you driving ☐ or a passenger ☐

Still employed (if work-comp injury)? ______ Still working (if car accident)? ________

What injuries are you seeking for this therapy:____

What doctors are you seeing for your injuries: ____

Doctor's name/phone prescribing this therapy: ____

What other therapy have you had for this injury:____

Current pain level 1-10 (10 most painful): ______________

What daily activities are affected by your injury: ____

Previous physical activities/ job abilities:____

Restrictions since your injury: ____

Have you had an Independent Medical Evaluation (IME) for this injury? _______When? ___/___/___

Name/Phone of attorney you have for this claim: ____

Other important information we need to know: ____

Signature of client ________________________________ Date ________________________

Insurance Client Waiver

I, ______________________________________, understand that I am fully responsible for the following:

1. Any and all charges denied or not covered by any insurance company handling my claim. Any and all charges accrued due to missed appointments or cancelled less than 24 hours in advance. These may not be billed to the insurance company. I understand that my therapy sessions are billed at $45.00 per 15 minute increment of therapy.

2. Maintaining a current prescription, providing a current copy for my file as well as any Independent Medical Examination reports regarding therapy. It is my responsibility to be aware of the number of sessions prescribed and any plans my doctor has for my progress. I will also notify my therapist if I change my doctor or add new therapies and attend any follow up appointments or regular appointments or tests or procedures requested by my referring doctor. I will also update any changes to my phone number or address.

3. Informing Lynne Ruby, the Insurance File Manager, at lynneruby1@charter.net or (231)498-2180 or fax to (303)484-5548 of any important information or communication with my insurance company. This may include, but is not limited to an appointment for an Independent Medical Evaluation, requests for information, denial of payment or therapy, settlement of my claim or reaching the limit of benefits. (We may be able to help you with these issues and support you and your therapy through the insurance process).

I authorize payment of benefits for my therapy to Pilates Health ConneXion. I authorize Pilates Health Connexion and Lynne Ruby, the Insurance File Manager, to release to my insurance company or my doctor, attorney or any other person I may designate, any information they may request regarding my injury, sessions notes, prescriptions and update letters. I also authorize release from my insurance company, my doctor, my attorney or any other person I designate to Pilates Health ConneXion or Lynne Ruby, the Insurance File Manager, any information needed to facilitate my therapy or the billing and payment of said therapy. I understand that while I may discuss insurance procedures with my therapist or Lynne Ruby, the Insurance File Manager, for this facility, I must seek an attorney for legal advice about my claim and take full responsibility for doing so if needed.

Signed ____ Date ___________________

Printed Name ______________________________________

Social Security # ___________________________________