Insurance Pre-Approval Form

Date _____

1. Patient's Name (last, first, middle initial): _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security Number: _____ Birth Date: _____ Sex: M ☐ F ☐

Patient Status: Single ☐ Married ☐ Other ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Other ☐ _____

2. Insured's Name (last, first, middle initial): _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security Number: _____ Birth Date: _____ Sex: M ☐ F ☐

Insurance Plan Name: _____ Insurance Policy or Group Number: _____

Claim Number: _____ Agent's Name and Phone: _____

4. Is patient's condition related to:

Employment? (current or previous): Yes ☐ No ☐ If Yes, name of employer: _____

Auto Accident? Yes ☐ No ☐ If Yes, in what state did it occur?: _____

Other Accident? Yes ☐ No ☐ If Yes, please specify: _____

5. Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical, government, and/or insurance benefits to Cara Wirt, LMT doing business as Balanced Massage.

Signed: _____ Date: _____

6. PAYMENT POLICY: I understand that my insurance contract is an agreement between the insurance company and myself. I acknowledge that your office is willing to prepare the necessary reports and assist me in collecting from the insurance company that which is due to Balanced Massage for my medically necessary care and treatment.
I understand and agree that I am ultimately responsible for payment of any balance due, including unpaid deductible and denied claims. If bills are not paid within 60 days by my insurance carrier, I am responsible for the balance on the 61st day. In the event that my insurance company does not pay in full for services provided, the balance will begin accruing interest at a rate of 1% per month as of the 90th day. In the event that fees are not paid as requested, a collection agency and possibly legal action may follow, and I will be responsible for all reasonable costs associated with collection of such fees, including attorney and court costs.

Signed: _____ Date: _____