BACK ON TRACK PHYSIOTHERAPY

DIRECT BILLING ENROLLMENT FORM

LAST NAME: _____ **FIRST NAME:** _____ **INITIAL:** _____

DATE OF BIRTH: _____ **PARENT/GUARDIAN:** _____
DAY / MONTH / YEAR — IF APPLICABLE

PRIMARY INSURANCE BENEFITS

PLEASE CHECK OFF THE INSURANCE COMPANY

- (●) CHAMBERS OF COMMERCE
- ( ) COWAN
- ( ) DESJARDINS
- ( ) GREAT WEST LIFE
- ( ) INDUSTRIAL ALLIANCE
- ( ) JOHNSON INC.
- ( ) MANULIFE
- ( ) SUN LIFE
- ( ) GREEN SHIELD
- ( ) STANDARD LIFE
- ( ) MAXIMUM BENEFIT
- ( ) OTHER _____

POLICY/ CLAIM #: _____ **ID/CERTIFICATE:** _____

NAME OF POLICY HOLDER: _____ **DOB:** _____
DAY / MONTH / YEAR

EMPLOYER: _____
IF DIFFERENT THAN ABOVE

SECONDARY INSURANCE BENEFITS: **PLEASE NOTE WE ARE CURRENTLY UNABLE TO BILL SECONDARY COVERAGE DIRECTLY**

PLEASE CHECK OFF THE INSURANCE COMPANY

- ( ) CHAMBERS OF COMMERCE
- ( ) COWAN
- ( ) DESJARDINS
- ( ) GREAT WEST LIFE
- ( ) INDUSTRIAL ALLIANCE
- ( ) JOHNSON INC.
- ( ) MANULIFE
- ( ) SUN LIFE
- ( ) GREEN SHIELD
- ( ) STANDARD LIFE
- (●) MAXIMUM BENEFIT
- ( ) OTHER _____

POLICY/ CLAIM #: _____ **ID/CERTIFICATE:** _____

NAME OF POLICY HOLDER: _____ **DOB:** _____
DAY / MONTH / YEAR

EMPLOYER: _____
IF DIFFERENT THAN ABOVE

BACK ON TRACK PHYSIOTHERAPY

DIRECT BILLING ENROLLMENT FORM

I hereby give permission to Back on Track Physiotherapy to direct bill my insurance company. I am aware that the payment will be sent directly to Back on Track Physiotherapy . I am also aware that if any services are not covered by the insurance company or if any payment is not received from the insurance company my account is my financial responsibility. I also understand that it is my responsibility to understand the parameters of my plan, whether a Physician referral is required, what percentage is covered & the annual limit.

I hereby agree to have the balance applied to my credit card. I understand my credit card will only be billed for unpaid amounts following 60 days of treatment. An itemized receipt will be emailed, if provided, or mailed to my address on file.

SIGNATURE **DATE**

CREDIT CARD INFORMATION

NAME ON CARD: _____ ◯ VISA ◉ MC

CARD NUMBER: _____ EXPIRY: _____ SECURITY CODE: _____
MM/YY

CARD HOLDER SIGNATURE: _____

BACK ON TRACK PHYSIOTHERAPY

NOTIFICATION FOR EXTENDED HEALTH COVERAGE

PHYSIOTHERAPY COVERAGE Maximum Coverage Per Calendar Year: _____ Maximum Cost Per Treatment: _____ Amount Remaining: _____ MD Referral Require: _____ Coverage Checked By: _____ Date: _____	**CHIROPRACTIC COVERAGE** Maximum Coverage Per Calendar Year: _____ Maximum Cost Per Treatment: _____ Amount Remaining: _____ MD Referral Require: _____ Coverage Checked By: _____ Date: _____
MASSAGE COVERAGE Maximum Coverage Per Calendar Year: _____ Maximum Cost Per Treatment: _____ Amount Remaining: _____ MD Referral Require: _____ Coverage Checked By: _____ Date: _____	**COMPRESSION SOCKS COVERAGE** Maximum Coverage Per Calendar Year: _____ Maximum Cost Per Treatment: _____ Amount Remaining: _____ MD Referral Require: _____ Coverage Checked By: _____ Date: _____
ACUPUNCTURE COVERAGE Maximum Coverage Per Calendar Year: _____ Maximum Cost Per Treatment: _____ Amount Remaining: _____ MD Referral Require: _____ Coverage Checked By: _____ Date: _____	**CUSTOM BRACING COVERAGE** Maximum Coverage Per Calendar Year: _____ Maximum Cost Per Treatment: _____ Amount Remaining: _____ MD Referral Require: _____ Coverage Checked By: _____ Date: _____
APPLIANCE(S) COVERAGE Maximum Coverage Per Calendar Year: _____ Maximum Cost Per Treatment: _____ Amount Remaining: _____ MD Referral Require: _____ Coverage Checked By: _____ Date: _____	**ORTHOTICS COVERAGE** Maximum coverage per calendar year: _____ Maximum cost per Pair: _____ Amount Remaining: _____ MD Referral Require: _____ Who can dispense (DC or PT): _____ Who can prescribe: _____ Coverage Checked By: _____ Date: _____
OTHER COVERAGE Type of Service/Product: _____ Maximum Coverage Per Calendar Year: _____ Maximum Cost Per Treatment: _____ Amount Remaining: _____ MD Referral Require: _____ Coverage Checked By: _____ Date: _____	**OTHER COVERAGE** Type of Service/Product: _____ Maximum Coverage Per Calendar Year: _____ Maximum Cost Per Treatment: _____ Amount Remaining: _____ MD Referral Require: _____ Coverage Checked By: _____ Date: _____

Able to bill online:

Assignment payable to clinic:

BACK ON TRACK PHYSIOTHERAPY

REFUSAL TO DISCLOSE INSURANCE INFORMATION

Refusal to Disclose Insurance Information

I, _____, do not wish to disclose my extended health care benefits insurance information to Back on Track Physiotherapy.

I am aware that the reason for this request is to keep track of my coverage and agree that I will personally keep track and be responsible for my account.

_____	_____
(Patient Signature)	(Administrator Signature)
_____	_____
(Date)	(Date)

Cancelation Policy

DATE: _____

Name: _____ DOB: _____
DOL: _____ Claim #: _____

We understand that unplanned issues may come up and you will need to cancel an appointment. If this happens, we respectfully ask that you notify us at least 24 hours prior to your appointment time.

Our therapists want to be available to meet your needs as well as the needs for all of our patients. When a patient does not show up for a scheduled appointment, another patient loses the opportunity to be seen.

If we are not provided with the appropriate notice, you will be responsible for a Missed Treatment charge of $50.00. For any Missed Massage Treatment, you will be charged in accordance with the RMTAO as follows: 2nd missed massage – 50% of the massage fee / 3rd missed massage – 100 % of the massage fee.

This charge will not be billed to any third-party payors, you will be billed, and it must be paid by you for you to continue to be treated under your claim. Under certain circumstances management may waive this fee.

By signing below, you understand and agree to the cancelation and payment policy.

_____ _____
Patient's Name Witness Name

_____ _____
Patient's Signature Witness Signature