physiomobility HEALTH GROUP

Patient ID: _____

INSURANCE SUBMISSION APPLICATION & AUTHOROZATION (Page 1/2)

PATIENT INFORMATION

First Name | *Last Name and Middle Initial* | *Date of Birth (DD/MM/YY)*

Street Address & Number | City | Province | Postal code

Home Phone Number | *Work Phone Number* | *Cell Phone Number*

INSURANCE POLICY INFORMATION

Primary Insurance Company

Policy/Group Number | *ID/Certificate Number*

Policy Holder's Name | *Policy Holder's Date of Birth (DD/MM/YYY)*

Were you referred to this service by a medical doctor ? ☐ Yes ☐ No

If **Yes**, Doctors name: _____

POLICY HOLDER INFORMATION ***(If different from patient):***

Last Name | *First Name and Initial(s)* | *Date of Birth (DD/MM/YY)*

Relationship to patient

CONSENT TO COLLECT & EXCHANGE PERSONAL INFORMATION

Message to the Plan member, Spouse and/or Dependent regarding Personal Information:
Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and/or plan abuse.

Continued on next page…

☐ ***Physiomobility*** DON MILLS
6 Maginn Mews, Suite 211
Shops at Don Mills
Tel: 416-444-4800
Fax: 416-444-4811

☐ ***Physiomobility*** THORNHILL
8150 Yonge St. Suite 1
Yonge & Uplands
Tel: 905-731-6777
Fax: 905-731-3336

☐ ***Physiomobility***
HOME HEALTHCARE
Central & North GTA
Tel: 416-444-9547
Fax: 416-444-4811

☐ ***Pain Management***
& Fibromyalgia Centre
6 Maginn Mews, Suite 211A
Tel: 416-444-0699
Fax: 416-444-4811

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INSURANCE SUBMISSION APPLICATION & AUTHOROZATION (Page 2/2)

AUTHORIZATION & CONSENT

I authorize my healthcare provider/ Physiomobility to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or administrator and their service provider(s) for the above purposes. I authorize the insurer and/or plan administrator and their service provider(s) to:

- Use my personal information for the above purposes
- Exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs relevant for the above purposes.
- Exchange personal information concerning any claims submitted with the plan member or person acting on behalf of the plan member.
- Exchange personal information for the above purposes electronically or in any other manner. I understand that personal information may be subject to disclosure to those authorized underapplicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original and may remain in effect for the continued administration of the group benefits plan.

DIRECT BILLING POLICY

I authorize Physiomobility to bill my insurance company directly. I understand that Physiomobility will bill the insurance company after the service is provided. I authorize the payment to be directly paid to Physiomobility and I will be personally liable for any outstanding balance not covered by my insurance company. I will notify Physiomobility if the payment from the insurance company is paid directly to my account. I understand that if for any reason Physiomobility does not receive payment within 30 days of the service date, I will be responsible for the payment.

I fully understand the above and agree to abide by this policy

_____ _____

Patient's/Guardian Last Name *Date*

_____

Signature

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