INSURANCE SUBMISSION APPLICATION & AUTHOROZATION (Page 1/2)

PATIENT INFORMATION:

First Name _____ Last Name and Middle _____ Initial Date of Birth (D/M/Y) _____

Address

_____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Primary Insurance Company: _____

Policy/Group#: _____ ID/Certificate No.:_____

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

If Yes, Doctor's Name: _____

POLICY HOLDER INFORMATION (If different from patient):

Last Name: _____

First Name and Initial(s): _____

Date of Birth (mm/dd/yyyy): _____

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.

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11685 Yonge St. Unit A106
Richmond Hill, ON L4E 0K7
Tel: 905-237-7174
Fax: 905-237-7184

INSURANCE SUBMISSION APPLICATION & AUTHOROZATION (Page 2/2)

AUTHORIZATION & CONSENT

I authorize my healthcare provider/Premier Care Physiotherapy 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 health care professionals, investigative agencies, insurers and reinsurers and administrators of government benefits or other benefits program 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 under applicable 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 Premier Care Physiotherapy to bill my insurance company directly. I understand that Premier Care Physiotherapy will bill the insurance company after the service is provided. I authorize the payment to be directly paid to Premier Care Physiotherapy and I will be personally liable for any outstanding balance not covered by my insurance company. I will notify Premier Care Physiotherapy if the payment from the insurance company is paid directly to my account. I understand that if for any reason Premier Care Physiotherapy 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's name:_____

Signature: _____

Date:_____

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