Altruistic
THERAPY SERVICES

Patient understands that Altruistic Therapy Services, LLC requests that any patient information be faxed at 866-886-6628 and or in person. It is at the patient's discretion to send any personal or medical information via e-mail and that e-mail is not HIPAA compliant. Initials _____

Patient Name:_____DOB:_____
Address:_____Phone:_____
_____ City_____Zip Code_____
Cell#_____
Is this auto related or worker's comp related?
Auto Accident:_____D.O.I:_____
Work Injury:_____D.O.I:_____

Primary Insurance
Name_____
Subscriber Name:_____DOB:_____
Group #_____ Contract # _____
Insurance Contact Name and Phone if injury related_____

Secondary Insurance
Name:_____
Subscriber Name:_____DOB:_____
Group #_____ Contract # _____
Insurance Contact Name and Phone if injury related:_____

Tertiary Insurance Name: _____
Subscriber Name:_____DOB:_____
Group #_____Contract #:_____
Insurance Contact Name and Phone if injury related: _____

***Authorization to Pay Benefits to Therapist**: I hereby authorize payment directly to Altruistic Therapy Services, LLC of the Therapy benefits, if any, otherwise payable to me for their services as described below but do not exceed the reasonable and customary charge for those services. I understand the provider's charge may exceed the private insurance carrier payment, and if greater than such payment, I will be responsible for that amount, and /or any deductibles or co-pays. Payment is due at the time of service, unless arrangements are made in advance.*

***Authorization to Release Information**: I hereby authorize Altruistic Therapy Services, LLC to release any information required by my health insurance company to pay my medical claims. As related to my examination and treatment.*

Signature:_____Date:_____