TRIANGLE PHYSIOTHERAPY & REHABILITATION

CLEAR FORM

Last Name:	**First Name:**
Date of Birth:	**Gender:** ☐ **M** ☐ **F**

EXTENDED HEALTH INSURANCE DIRECT BILLING POLICIES

- We are able to bill some (Sunlife, Great West Life, Manulife, Johnson's Inc, Chamber of Commerce, Standard Life, Industrial Alliance, Desjardin, Maximum Benefit, Nexgen Rx, Greenshield & Bluecross as well as VAC & RCMP plans) insurance companies directly for your physiotherapy treatments. Please confirm with the receptionist, the details of your insurance plan.
- As the policy holder, it is your responsibility to contact your insurance company and confirm the exact details of your coverage including requirements for physician requisitions. Our front desk staff would be happy to assist you with any questions regarding your insurance coverage for our services.
- **You may be required to pay a deductible or make a co-payment if your insurance plan defines so. Deductibles & co-payments are due at the end of your visit. Any unpaid balances will be charged to your credit card on file.**
- We are only able to direct bill to your primary insurance plan. We are not able to do any co-ordination of benefits to secondary plans (spouse or other parent's plan).
- We are not able to direct bill Massage Therapy treatments.
- If you have been involved in a motor vehicle accident & have extended health insurance, your auto insurer requires your treatments to be billed to the extended health plan first. Please provide primary & secondary (if applicable) insurance information below.

EXTENDED HEALTH INSURANCE INFORMATION

Name of Insurance Company (PRIMARY PLAN):	
Group/Policy/Plan No:	Certificate ID No:
Name of Plan holder:	
Plan holder's Date of Birth:	Name of Employer:
Are you covered under any other group insurance plan (Spouse, Parents)? ☐ Y ☐ N	
If Yes, provide information below.	
Name of Insurance Company (SECONDARY PLAN):	
Group/Policy/Plan No:	Certificate ID No:
Name of Plan holder:	
Plan holder's Date of Birth:	Name of Employer:

AUTO INSURANCE INFORMATION (IF APPLICABLE)

Name of Insurance Co:	
Address:	
Name of insured:	
Policy No:	Claim No:
Date of Accident:	
Name of Adjuster:	Telephone:

W.S.I.B INFORMATION (IF APPLICABLE)

W.S.I.B Claim No:	Date of Injury:	
Adjudicator Name:	Tel:	Fax:
Employer Name:		
Employer Address:		
Employer Telephone:	Fax:	
Are you currently working? ☐ Y ☐ N	If not, when did you last work?	
Does your employer have work duties that you can do while recovering? ☐ Y ☐ N		
Do you have extended health coverage? ☐ Y ☐ N (If YES, please fill out information above)		

NOTE: You will be required to pay a $15.00 charge for your own set of electrodes which will not be covered by the WSIB. **Initial here:**

TRIANGLE PHYSIOTHERAPY & REHABILITATION

EXTENDED HEALTH INSURANCE, WSIB & HCAI (AUTO INSURANCE) DIRECT BILLING CONSENT

- I _____, authorize Triangle Physiotherapy to bill my treatments directly through Telus E-Health Solutions Portal, Greenshield, Bluecross provider portal, HCAI or WSIB e-billing or any other applicable billing portal. I understand that Triangle Physiotherapy will bill the insurance company after the service is provided.
- I authorize the payment to be directly paid to Triangle Physiotherapy and I will be personally liable for any outstanding balance not covered by my insurance company.
- I will notify Triangle Physiotherapy if payment from the insurance company is paid directly to my account.
- In the event that WSIB rejects my claim, I understand that I will be responsible for payments for any treatments I have received at Triangle Physiotherapy.
- In the event that the auto insurance denies my treatment plan, I understand that I will be responsible for payments for any treatments I have received at Triangle Physiotherapy.
- I understand that if for any reason Triangle 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.

X _____ **X** _____

Patient / Parent / Guardian's Signature Date

For Office Use Only			
Date of Call:	**Time of call:**	**Initials:**	**Name of agent at Insurance:**
Primary Insurance Company:		☐ Calendar Year ☐ Benefit Year	
Eligible for online billing? ☐ Y ☐ N		Are Benefits Assignable? ☐ Y ☐ N	
Physiotherapy	Massage Therapy	Acupuncture	Orthotics/Shoes
Annual max: $	Annual max: $	Annual max: $	Orthotics:
% covered:	% covered:	% covered:	Can PT dispense?
Per Visit Max: $	Per Visit Max: $	Per Visit Max: $	Shoes:
Dr. ref. reqd. ☐ Y ☐ N	Dr. ref. reqd. ☐ Y ☐ N	Dr. ref. reqd. ☐ Y ☐ N	
Annual deductible: $	Annual deductible: $	Annual deductible: $	Annual deductible: $
Braces: Can PT prescribe? ☐ Y ☐ N		Compression stockings: ☐ Y ☐ N Min. compression: No. of pairs:	
Secondary Insurance Company:		☐ Calendar Year ☐ Benefit Year	
Eligible for online billing (SL, GWL)? ☐ Y ☐ N		Are Benefits Assignable? ☐ Y ☐ N	
Physiotherapy	Massage Therapy	Acupuncture	Orthotics/Shoes
Annual max: $	Annual max: $	Annual max: $	Orthotics:
% covered:	% covered:	% covered:	Can PT dispense?
Per Visit Max: $	Per Visit Max: $	Per Visit Max: $	Shoes:
Dr. ref. reqd. ☐ Y ☐ N	Dr. ref. reqd. ☐ Y ☐ N	Dr. ref. reqd. ☐ Y ☐ N	
Annual deductible: $	Annual deductible: $	Annual deductible: $	Annual deductible: $
Braces: Can PT prescribe? ☐ Y ☐ N		Compression stockings: ☐ Y ☐ N Min. compression: No. of pairs:	