



BENEFITS FORM

Patient's Name:		Date of Birth:	
Mailing Address:		Home Phone #:	
Parent/Guardian Name:		Mobile Phone #:	
E-mail address:		Alternate mobile #:	
Alternate E-mail:		Pediatrician:	
Primary Insurance:		Secondary Insurance:	
Provider info #:		Provider Info #:	
Subscriber's Name:		Subscriber's Name:	
Subscriber's DOB:		Subscriber's DOB:	
Policy ID#:		Policy #:	
Group #:		Group #:	
Employer Name:		Employer Name:	
Diagnosis (if known):			

INSURANCE BENEFIT COVERAGE (TO BE COMPLETED BY INSURANCE COORDINATOR)			
	Occupational	Physical	Notes
Annual Deductible:			
Coinsurance/Copays:			
Number of visits allowed:			
Deductible/OOP YTD:			
Authorization Required?			
Effective Date of Policy:			
Exclusions to the policy?			
Developmental Testing:			
Insurance Rep's Name:		Date of call:	

My signature indicates that all information provided above is accurate and current. I understand that if my insurance information changes at any time, it is my responsibility to notify a representative of Powerhouse Therapy of the noted changes. Failure to do so will result in my responsibility for payment of services if insurance denies services due to lack of authorization and/or verification of benefits. Please note: verification of benefits does not ensure payment of services.

Parent/guardian: _____ Date: _____
Signature

PLEASE MAIL TO Powerhouse Therapy, 1525 Haven Crest Drive, Powder Springs, GA 30127

FAX 1-866-430-3367 **EMAIL** info@constrainttherapy