ELITE PHYSIO
www.elitephysio.ca
Operating under: Michael F. V. Hofstatter Physiotherapy Professional Corperation

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DIRECT BILLING INFO SHEET

Patient Name: _____ **DOB:** _____

Member Name: _____ **DOB:** _____

Insurance Company Name: _____ **Assignment of Benefits Allowed?** Yes/No

Plan Contract #: _____ **Member ID#:** _____

Services	Max. Coverage ($)	Coverage (%)	Benefit Year	Doctor's note (please circle)	Combined with: (if applicable)	Name of Doctor & Date or Prescription (if required)
Physiotherapy				Yes / No		Name: _____ Date: _____
Chiropractic Care				Yes / No		Name: _____ Date: _____
Massage Therapy				Yes / No		Name: _____ Date: _____
Acupuncture				Yes / No		Name: _____ Date: _____

Additional Notes:

_____

_____

- I hereby understand that the clinic is responsible for submitting the claim only to the above services I have indicated.
- I hereby sign my benefits payable for treatment provided by **Elite Physio** and authorize payment directly to the clinic/owner.
- My insurance company may discuss details of the above services with **Elite Physio**.
- I understand that payment is due at the time **Elite Physio's** services are rendered to me.
- I hereby understand that by filling out and submitting this form, the clinic will not be held responsible for monitoring my benefit usage.
- If, at any time, payment is sent to me after **Elite Physio** has submitted the claim, I will be responsible for settling the balance in my account regarding submission dates.
- If, at any time, my benefit runs out after **Elite Physio** has submitted the claim, I will be responsible for settling the balance in my account regarding the submission dates.

Print Name: _____

Signature: _____

Date: _____