Lifetime Health & Wellness

INSURANCE FORM

POLICY INFORMATION

Patient Name: _____ Name of Insured (If Different): _____

Name of Insurance Company: _____ Insured's Date of Birth: _____

Insurance Subscriber ID: _____ Group ID: _____

I understand and agree that insurance policies are an arrangement between the insurance carrier and the insured. I understand and agree that all services rendered and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate care/treatment, any fees for professional services rendered will be immediately due and payable.

X_____ Date: _____
Signature of Patient or Parent/Guardian

CONSENT TO TREAT, SUBMIT INSURANCE CLAIMS & ASSIGNMENT OF BENEFITS

I hereby authorize LIFETIME HEALTH & WELLNESS, through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. I further authorize LIFETIME HEALTH & WELLNESS to furnish the appropriate agencies, for the purpose of billing, any information acquired during the course of my treatment and to send me notices and reminders of my appointments via text messaging. I am assigning my therapy benefits to LIFETIME HEALTH & WELLNESS for the services in which I receive and authorize my insurance carrier to make payments to LIFETIME HEALTH & WELLNESS on my behalf. LIFETIME HEALTH & WELLNESS reserves the right to seek reimbursement from any and all of your insurers regardless of whether you provide us with their contact information, unless you instruct us to bill you directly. All records released require an administrative and copying fee paid to LIFETIME HEALTH & WELLNESS before they are released, regardless of requestor. LIFETIME HEALTH & WELLNESS is HIPAA compliant with regard to information sharing policies.

By signing this document, I acknowledge that I have read, understand and agree that the information contained in this document including insurance benefits and any information I have presented to verify my own identity including my state issued driver's license, state issued photo identification card or my passport, and if applicable any information used to verify the identity of a minor beneficiary is current, correct and complete to the best of my knowledge. I agree to the financial terms stated above and as elsewhere outlined in LIFETIME HEALTH & WELLNESS'S Office Policies.

X_____ Date: _____
Signature of Patient or Parent/Guardian

ELIGIBILITY & VERIFICATION OF BENEFITS

As a courtesy we will file claims to your insurance on your behalf and we will verify your insurance eligibility. This does not guarantee coverage or payment of any benefit. We will estimate your benefits but if payments are denied or your insurance company fails to pay its portion, you are responsible for the entire fee.

x_____ (Initial)

If our services or our providers are not covered under your insurance plan the patient and or guardian is responsible for payment of all charges. In some cases, your insurance may not cover certain services or may have coverage limits in place, if so, the patient and or guardian is responsible for the charges. Limited coverage on routine, preventive healthcare is common. Please review your insurance plan. Patients are responsible for all non-covered charges as well as what your insurance considers the patient's responsibility.

x_____ (Initial)