



SECONDARY BILLING AUTHORIZATION

ATTENTION AUTO ACCIDENT & WORKER'S COMP CLAIMS: Claim number, adjustor, insurance carrier's phone number and address **must** be provided by your 3rd visit or you will be held responsible for payment. The adjustor must approve authorizations on these claims in order to continue therapy.

If for any reason, the party, which I instruct Bodywise Physical Therapy to bill on the day of my first appointment, does not pay **my balance in full or does not pay at all**, I authorize Bodywise Physical Therapy to bill one of the following:

A) My attorney:

Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____ Fax #: _____

I understand I am responsible for obtaining a letter of protection from my attorney for my balance.

B) My health insurance:

Company: _____

ID#: _____

Address: _____

City, State, Zip: _____

Phone #: _____ Fax #: _____

I understand that I am responsible for obtaining an insurance referral from my Primary Care Physician, if required by my health insurance.

Print Patient's Name: _____

Date: _____

Patient Signature: _____