Altamont Physical Therapy
122 Maple Avenue
PO Box 426
Altamont, NY 12009
518-861-6608

INSURANCE STATUS FORM

PATIENT NAME: _____

PRIMARY INSURANCE: _____

GUARANTOR NAME AND DATE OF BIRTH_____

CO-PAYMENT AMOUNT FOR PRIMARY INSURANCE: $_____

SECONDARY INUSRANCE: _____

CO-PAYMENT AMOUNT FOR SECONDARY INSURANCE: $_____

Have you ever had a **Workers' Compensation** or **No Fault Claim**? Yes No
If yes, then for what?_____

The above insurance coverage information is not a guarantee of payment. We do not accept responsibility for any incorrect information given to us by you or your insurance carrier. Your health insurance company will be billed, according to the information you have provided, and in the event the insurance carrier denies payment, ultimate **PAYMENT IS YOUR RESPONSIBILITY**.

Insurance plans may be limited to a specific number of visits per calendar year. We ask that you call and verify this with your Insurance Carrier. We do NOT have access to Insurance Plans for this information. Failure to inform the office, of your maximum total visits allowed by your plan per calendar year, will result in you paying out of pocket for all visits not covered. **We ask that you also notify your physical therapist and/or receptionist if you have previously received physical therapy for the same diagnosis during this year**. Failure to inform our office, of previous physical therapy treatments may result in **you being responsible for payment** of all services rendered.

Altamont Physical Therapy is NOT responsible for knowing your specific insurance plan requirements. If you have any questions regarding your plan, it is your responsibility to call your insurance carrier.
I have read and acknowledge to the above information.

_____ _____
Patient Signature Date