



15811 Ambaum Blvd SW Suite 140, Burien WA 98166
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PLEASE PROVIDE THE FRONT DESK WITH YOUR PRIMARY AND SECONDARY INSURANCE CARDS.

Primary Insurance ID number Group number

Secondary Insurance ID number Group number

NOTE: We do not bill for secondary insurance plans. We require this information to ensure your provider is credentialed with your secondary insurance plan.

Name of referring physician: First name Last name Designation

Physician address: City State Zip

Physician phone number () Fax ()

IF THIS IS AN L&I CLAIM, PLEASE FILL OUT THE FOLLOWING INFORMATION:

Labor and Industry Claim Number:

Claim Manager: PHONE ()

IF THIS IS A PERSONAL INJURY CLAIM, PLEASE FILL OUT THE FOLLOWING INFORMATION:

Name of Auto Insurance Company:

Adjuster/Claim Manager Name:

Claims Address: Street City State Zip

Phone () Claim #:

- Please note that Co-pays are collected at the time of visit.

Patient's or authorized person's signature:

- I authorize the release of any medical records or other information necessary to process this claim.

Signed Date

Insured's or authorized person's signature:

- I authorize payment of medical benefits to LAKE BURIEN PHYSICAL THERAPY, INC.
I hereby agree and consent to the plan of care proposed to me by the physical therapist to whom I have been referred. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse physical therapy services. I will ask for any information I want to have about my physical therapy care and will make my wishes known to the practitioner and/or staff. I understand that my insurance may deny payment based on non-covered services or medical necessity. Any portion of charges not paid by the insurance company will be billed to me and is then due and payable within 30 days of invoice. Payment plans are available.

Signed Date