REBALANCE
SPORTS MEDICINE
rebalancetoronto.com

DIRECT BILLING APPLICATION FORM

CLIENT INFORMATION

Last Name:	First Name and Initial(s):	Date of Birth (yyyy-mm-dd):	Gender ❑ M ❑ F

Insurance Provider:	Policy/Contract Number:	Member ID:

Were you referred to this service by a doctor? ❑ Yes ❑ No

Doctor's Name:

CARDHOLDER INFORMATION

Same as above? ❑ Yes ❑ No

Last Name:	First Name and Initial(s):	Date of Birth (yyyy-mm-dd):

Relationship to Cardholder:	Cardholder Phone #:

DIRECT BILLING POLICY

Electronic Claims Transmission Authorization:

_____ Initials

I authorize Rebalance Sports Medicine (RSM) to bill my insurance company electronically through Telus E-Health Portal, Greenshield Portal or Bluecross Portal. Due to the high number of claims processed, I understand that RSM will bill my insurance company on the service date prior to the appointment time.

Assignment of Benefits:

_____ Initials

I authorize the insurer/plan administrator to issue payment directly to RSM and I will be personally liable for any outstanding balance not covered by my insurance company. I understand that this Assignment will apply to all eligible claims submitted by RSM and that I may revoke it at any time by providing notice. If I am a spouse/ dependent, I confirm that I am authorized by the plan member to execute an Assignment of benefit payments to RSM. I will notify RSM if the payment from the insurance company is paid directly to my account. I understand that if for any reason RSM does not receive payment within 30 days of the service date, I will be responsible for the payment.

Consent to Collect and Exchange Personal Information:

_____ Initials

I authorize RSM to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer/plan administrator and their service providers and any relevant organizations for the purpose of assessing claims, underwriting, investigating, auditing, administering the group benefits plan, including investigation of fraud and/or plan abuse. If I am a spouse/dependent I authorize RSM to disclose the above information to the plan member if required for the above purposes.

We kindly ask that you always bring an alternate form of payment to each visit. Although it is rare, there are specific circumstances that can prevent us from submitting your claim electronically including but not limited to technical issues, maximum coverage being reached and/or randomized insurance company audits.

I fully understand the above and agree to abide by this policy:

_____ Patient Signature

_____ Date