MAPLE RIDGE
PHYSIOTHERAPY
& PAIN CLINIC

Chronic Pain, Orthopaedics & Sports Injuries, Acupuncture,
Massage Therapy, ICBC and WorkSafeBC Claims
#102-22561 Dewdney Trunk Road Maple Ridge, BC V2X 3K1
Phone: (604) 467-8775 . Fax: (604) 467-8704
www.mapleridgephysio.com

DIRECT BILLING AUTHORIZATION

Maple Ridge Physiotherapy and Pain clinic is able to bill some insurance companies (e.g. Pacific Blue Cross) directly for your treatments. As the policy holder, it is my responsibility to contact my insurance company and confirm the exact details of my coverage including requirements for physician requisitions.

I understand I may be required to pay a deductible or make a co-payment if my insurance plan defines so. Deductibles & co-payments are due at the beginning of your visit.

I give consent for any unpaid balances to be charged to my credit card (if present on file).

Maple Ridge Physiotherapy and Pain clinic is only able to direct bill to your primary insurance plan. Maple Ridge Physiotherapy and Pain clinic is not able to perform any co-ordination of benefits to secondary plans (spouse or other parent's plan).

I understand that if my claim is to be submitted directly to an outside agency for payment, and for any reason the third-party payer denies the claim and/or refuses to pay all or any of the full amount billed, I am fully and solely responsible for paying the outstanding amount.

☐ **Check here to indicate that you have read and agree to the above statements.**

Extended Health Direct Billing Form:

☐ **Pacific Blue Cross** ☐ **Canada Life** ☐ **Other : _____**

Primary policy holders name: _____
Relation to policy holder (self, spouse, child): _____
Policy holders Date of Birth (YYYY/MMM/DD) :_____
Policy/Plan Number: _____
ID Number: _____

Electronic Transmission Authorization

Please check below to give Maple Ridge Physiotherapy and Pain clinic permission to electronically submit claims for your Physiotherapy/Massage treatments to your insurer.

☐ **I agree.**

Assignment of Benefits

Please check below to give Maple Ridge Physiotherapy and Pain clinic permission to collect claim payments for your Physiotherapy/Massage Therapy treatments from your insurer.

☐ **I agree.**

_____ _____
Patient Name Date (YYYY/MMM/DD)

☐ **I agree that checking this box constitutes an electronic representation of my signature.**