

# NELL MEAD

## PHYSIOTHERAPIST

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### INSURANCE DETAILS

If you plan to pay for your treatment with Nell through your health insurance, please complete this form and hand it to Nell at your first session.

Name: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Authorisation Number: \_\_\_\_\_

Number of sessions or cost limit authorised: \_\_\_\_\_

Is the policy in someone else's name? YES NO (please circle as appropriate)

If so, please let us know who, & your relationship to them: \_\_\_\_\_

Do you have an excess to pay? YES NO (please circle as appropriate)

If excess payable, how much is it? \_\_\_\_\_

Does your insurer agree for us to invoice them directly? YES NO (please circle as appropriate)

I confirm that these details are correct to the best of my knowledge.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

(If you are the patient and you are under the age of 18, a parent/guardian must sign for you)

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