The Rehab Doctors PC

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APPOINTMENT INFORMATION

Doctor who requested or scheduled your appointment with us: _____ ❍ NA – Self Referral

Have you been a patient here before? ❍ Yes ❍ No Have you obtained pre-authorization for your appointment? ❍ Yes ❍ No ❍ NA

Has your primary care physician provided a referral authorization for this appointment? ❍ Yes ❍ No ❍ NA

Date of Accident/Injury: _____/_____/_____ **OR** **Date Symptoms began** _____/_____/_____

Type of Accident: ❍ at work ❍ at home ❍ auto ❍ other (explain):_____

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (M.I.) _____

Address:_____ City: _____ State: _____ Zip: _____

Date of Birth _____/_____/_____ Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Marital Status: _____

Home Phone (_____) _____ Cell Phone (_____) _____ Sex: ❍ M ❍ F

Employer: _____ Position: _____

Work Phone (_____) _____ Email _____

Spouse's Name: _____ Spouses SSN ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Spouse's Employer: _____ Spouse's Work Phone: (_____) _____

Person to call in case of an emergency: _____ Relationship: _____
(other than spouse)

Home Phone (_____) _____ Other Phone (_____) _____

Name of family, friends or others that we may communicate with regarding appointments; treatment; prescriptions; test results; billing and insurance: _____

PERSONAL HEALTH INSURANCE INFORMATION (Attach copies of your insurance card(s))

1st Insurance to be billed: _____ Policyholders Name: _____

Policy #:_____ Group #: _____ Policyholders Name: _____ DOB: _____

Phone Number: (_____) _____ Patient's relationship to Policyholder: _____

2nd Insurance to be billed: _____ Policyholders Name: _____

Policy #:_____ Group #: _____ Employer: _____

Insurance Claims Address: _____ Policyholders Name: _____ DOB:_____

Phone Number: (_____) _____ Patient's relationship to Policyholder: _____

MOTOR VEHICLE ACCIDENT INSURANCE INFORMATION

Your motor vehicle insurance carrier: _____ Claim #: _____

Address: _____ Phone #: _____ Contact: _____

Other party's motor vehicle insurance carrier: _____ Claim #: _____

Address: _____ Phone#: _____ Contact: _____

Which motor vehicle insurance carrier will we send the claim to: _____

State in which accident occurred: _____

Please continue on back!

Have you retained the services of an attorney in connection with your injury or illness? ❍ *Yes* ❍ *No*

Attorney: _____ Phone #: _____

WORKER'S COMPENSATION INSURANCE INFORMATION

If your appointment is the result of a work related injury or in connection with a worker's compensation claim, please complete the information below. **Your visit to our office must be authorized by the worker's compensation insurance carrier or your employer prior to your appointment or we may be required to reschedule your appointment.**

Employer at the time of your injury: _____ Phone #: (_____) _____

Address: _____ Contact Person: _____

Worker's Compensation Insurer: _____ Contact Person: _____

Address: _____

Phone #: (_____) _____ Claim #: _____

Case Manager: _____ Phone #: (_____) _____

GUARANTOR OF PAYMENT

Please complete this section with parent or custodial information if the patient is a minor

Name: (Last) _____ (First) _____ (M.I.) _____

Address (City, State, Zip): _____

Date of Birth ____/____/____ Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Marital Status: _____

Home Phone (_____) _____ Other Phone (_____) _____ Sex: ❍ M ❍ F

Employer: _____ Position: _____

Work Phone (_____) _____ ❍ Full Time ❍ Part Time No. of Years Employed: _____

ACCEPTANCE OF FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I hereby authorize payment of benefits on my behalf by my insurance plan or any government-sponsored plan directly to The Rehab Doctors, P.C. I understand that, if the providers of The Rehab Doctors, P.C. are not providers with my insurance plan, I am responsible to The Rehab Doctors, P.C. for amounts determined ineligible by my insurance plan due to its "maximum allowable" or other internal payment policies. I agree to pay any co-pays, deductibles or co-insurances that are my responsibility under my insurance plan(s). I understand that I will be billed and held responsible for my account regardless of the status of any insurance claim(s). I have read, had my questions answered and agree to comply with this statement.

Signed: _____ Date: _____

AUTHORIZED TO RELEASE MEDICAL INFORMATION

I hereby authorize The Rehab Doctors, P.C. to release medical records and other information necessary to determine benefits, process claims for payment, or upon requests by other providers involved in my continued or future care. I authorize any insurance company, organization, employer, hospital, physician, dentist or pharmacist to release any information required to process my claim(s) or to provide continued for future care.

Signed: _____ Date: _____

AUTHORIZED BY MEDICARE BENEFICIARIES

If I am a Medicare beneficiary, I certify that the information given to me in applying for payment under Title 18 of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim form. I request that payment of authorized benefits be made on my behalf.

Signed: _____ Date: _____